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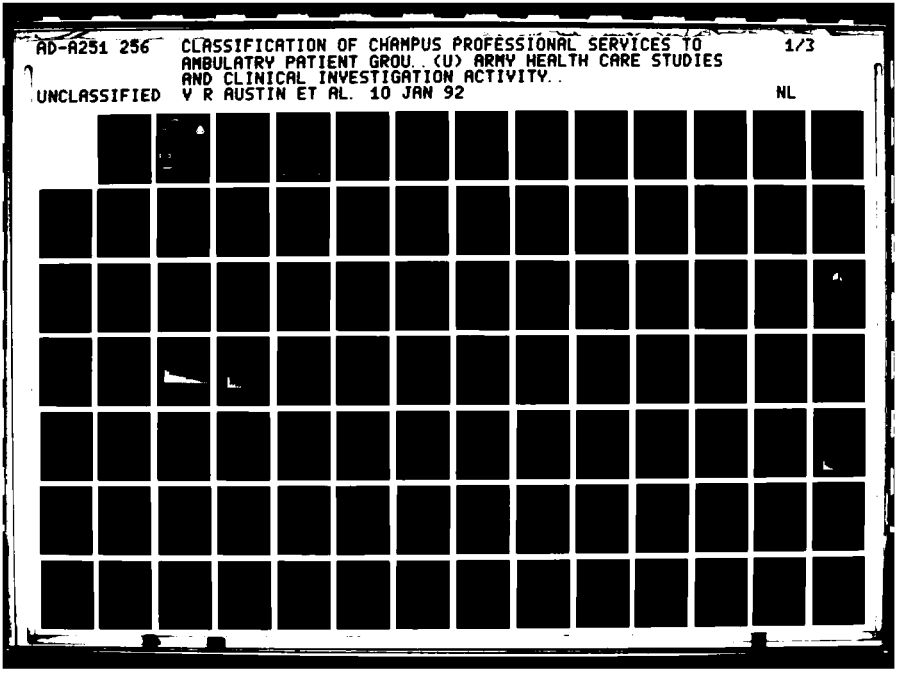

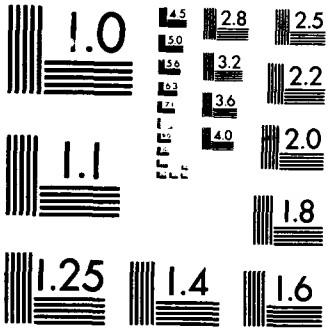

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TRI-SERVICE CHAMPUS STATISTICAL DATABASE PROJECT (TCSDP)

CLASSIFICATION OF CHAMPUS PROFESSIONAL SERVICES TO AMBULATORY PATIENT GROUPS AND ASSIGNMENT OF RESOURCE-BASED RELATIVE VALUES

CHAMPUS PROFESSIONAL SERVICES CLASSIFICATION STUDY (CPSCS)

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HR 92-002
JANUARY 1992

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This Report presents classification of CHAMPUS professional services data for Fiscal Year 1989 to Ambulatory Patient Groups (APGs) and assignment of Resource Based Relative Values (RBRVS) from the Physician's Fee Schedule for Medicare Patients. CHAMPUS professional services claims data for all three military service catchment areas were extracted from the Tri-service CHAMPUS Statistical Database Project files. The study shows that claims data can effectively be used for research, how encounters can be developed from claims data, and how APGS and RBRVSs can be applied as a tool for resource alloca tion. More than sixty-two percent of the variance in resources was accounted for by APG groupings. Both APGs and RBRVS lend themselves to analysis of large data sets, and this research indicates that they are very appropriate for application to CHAMPUS professional services claims data for allocation of resources.

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SUMMARY

Professional services claims constitute the bulk of the Tri-service CHAMPUS Statistical Database Project (TCSDP) data. Because of spiraling costs within Department of Defense (DOD) health services, and particularly within the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), better methods are required to assess current resource allocations as compared to service requirements.

Classification of ambulatory care data to Ambulatory Patient Groups (APGs) provides this tool, and indeed has been accomplished in the Professional Services Classification Study (PSCS). This case-level classification system provides information to analysts and policy makers that will enable them to make better decisions based on resources available and medical services requirements.

Encounter files were developed from the claims data so that APG classification could be accomplished. Encounters were built by joining or separating claims by "care begin date". The resulting encounter enables APGs to be assigned and consolidation or ancillary packaging of procedures to be flagged. This is possible because the services provided on a single day are aggregated on the Encounter record, enabling the APG grouper software to evaluate one service against another in terms of most important or resource intensive.

Resource Based Relative Values from the fee schedule for physician's services were also assigned for each procedure code.

The schedule contained values for almost one hundred percent of the codes used in the CHAMPUS files.

All encounters were assigned both RBRVS values and APGs, and the analysis up to this point in the study uses all encounters. However, it is planned to separate the encounters to those that are facility based and those provided from an office setting. The facility based encounters will then be analyzed using APG assignments, while the office-based encounters will use the RBRVS values.

In the APG analysis on all encounter records, sixty-two percent of the variation in allowed charges was accounted for by the APG groupings. Although this R-square statistic is high when compared with research results using other classification systems, it is anticipated that the use of only facility-based encounters will significantly increase this percentage.

It is expected that use of the fee schedule in the Medicare program will increase cognitive service payments and decrease invasive procedure payments. Implementation of the RBRVS fee schedule in the CHAMPUS payment for physician services is likely to see the same pattern.

Classification of ambulatory data to Ambulatory Payment Groups and assignment of Resource Based Relative Values gives managers and policy makers new tools for determination of resource requirements, allocation of resources, and evaluation of medical care being provided. In this age of scarcity and redistribution of resources, the capability of comparing case mix of care rendered and case level measures among providers, sites

of service, departments, regions, and programs increases in importance. Capabilities demonstrated by this study will provide the necessary tools for new and improved analysis techniques for the short term, with improved health care delivery as the long-term potential benefit.

ACKNOWLEDGMENTS

There are many persons who have contributed in some way to this Report. First, we could not have even begun the project without the CHAMPUS professional services data. Within our organization, US Army Health Care Studies and Clinical Investigation Activity (HCSCIA), our Division Chief, Dr. Scott Optenberg, helped tremendously in making the data available, offering his expertise in the formation of the data base, and interpretation of the data as well as the project design. His consultative support has been invaluable throughout every phase of the project, and we appreciate his contributions.

We have also had outstanding programming support within HCSCIA. Ms. Paulinda Pangaldan, Mr. Ricardo Maldanado, Ms. Catherine Stein, and Ms. Kathleen Moon have all written complex computer programs to manage and analyze the large data files. We appreciate their support.

There have also been several people outside our activity who have contributed to this project. Dr. Joanna Lion and Mr. Al Malbon, of Brandeis University, along with Mrs. Margaret Sulvetta, of Urban Institute, have shared their ideas and research to assist us in this project. Dr. William Koprowski, a faculty member of Medical University of South Carolina and formerly a Robert Wood Johnson fellow at Physician Payment Review Commission, helped us interpret the cost data.

Mr. Richard Averill and his staff at 3M Health Information Systems generously provided software and expertise to facilitate

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Without the contributions of all these people, the work documented in this report could not have been accomplished. We wish to thank each one for their contribution; we appreciate it very much.

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INTRODUCTION

Purpose

The purpose of this study is to evaluate the use of diagnosis and procedure based, or case-level, ambulatory classification systems, i.e., Ambulatory Patient Groups (APGs) and Resource-Based Relative Value Scales (RBRVS), as tools for allocation of resources in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Additionally, a data base for further ambulatory care classification research will be established, along with the software tools necessary to group ambulatory data.

This report addressess classification issues. Future reports will address weight development for the APGs, conversion factors for the RBRVS, and case mix profiles for clinics, catchment areas, military services, Department of Defense (DOD), and/or geographic areas.

Background

The Department of Defense Military Health Services System (MHSS) serves a population of almost ten million beneficiaries, thus comprising one of the largest health care systems in the world. The MHSS direct care system provides care for approximately a million inpatients and has almost fifty million outpatient clinic visits annually (Gisin, 1990). DOD spent $13.1 billion for health care in 1989 (Kenkel, 1991).

As a companion to the direct care furnished in military hospitals and clinics, care is also provided to DOD beneficiaries by civilian providers of care through CHAMPUS. The Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) processes more than five million claims annually. In 1989, the OCHAMPUS annual budget was approximately $1.5 billion, which is a significant portion of the overall DOD MHSS budget (Defense Medical Systems Support Center, 1989).

CHAMPUS and the MHSS direct care system used to be funded through separate appropriations and budgeting. However, in 1988 the CHAMPUS budget was allocated directly to the military departments. Beginning in 1989, CHAMPUS dollars were allocated to military hospitals by catchment area, or generally areas within a 40-mile radius of the military hospital (Badgett, 1990).

However, in spite of efforts to gain control of escalating health care costs, they continue to rise. Significant budget overruns in CHAMPUS expenditures make it imperative that Department of Defense, as well as the individual military services, better plan and project workload and resource requirements for medical care provided through CHAMPUS. Within the CHAMPUS budget, professional services in ambulatory care constitute the bulk of the claims. Professional services data from CHAMPUS have been used for this study.

Except for special demonstration projects such as Catchment Area Management or Gateway to Care, Army Medical Department (AMEDD) budgeting for in-house ambulatory care is currently based on Ambulatory Work Unit (AWU) weights, which are clinic

specific (J. Jensen, personal communication, January 10, 1992). Each visit to a clinic is assigned a predetermined weight for that clinic, regardless of the condition of the patient being treated or the procedure performed. A similar system for CHAMPUS budgeting has been considered as an interim measure for cost control. However, it is generally recognized that a case-level classification system based on diagnoses and procedures would be a better indicator of resources required. The Diagnosis Related Groups (DRGs) are being used for this purpose for inpatients in the MHSS direct care system, CHAMPUS and Medicare programs, and for most other third-party payments. However, there is currently no nationally-accepted counterpart for the ambulatory setting.

For the last several years the Medicare program has also experienced tremendous cost increases. Spending for physicians' services is the second largest component (after hospital expenditures) of Medicare expenditures and the third largest Federal domestic program. Costs for physicians services increased at an annual compound rate of 16 percent during the ten year period from 1978 to 1987 (Kay, 1990). As a result, Medicare spending for Part B physicians' services has been the major focus in efforts to reduce costs and bring about physician payment reform.

Additionally, there has been a shift of services from the hospital inpatient setting to ambulatory care. Ambulatory surgery has increased tremendously. In 1986, over forty percent of hospital surgery was performed on an outpatient basis, compared to only sixteen percent as recently as 1980 (Lion, Collard, Malbon, Vertrees, & Mowschenson, 1988).

One of the reasons for the high cost of medical care is that there is no true competition in the health care industry (Deatsch & Shaw, 1990). For the most part, payments for services come from third party payers rather than from the patients receiving care.

Under the CHAMPUS program patients pay only a portion of the costs for care. However, their incentive to shop for medical care is low because of small co-payments and the advantages of getting appointments faster than in the direct care system.

The concern and move toward controlling spiraling costs for health care is not unique to Department of Defense, but is universal in health care in the United States. Department of Defense can benefit, however, from the research and programs instituted in other agencies and systems.

The classification system of Diagnosis Related Groups (DRGs) was introduced and implemented for inpatient care within the Medicare Prospective Payment System (PPS) in 1983. The unit of payment under the DRG PPS is the hospital discharge. Predetermined rates have been established for each DRG. This has proven to be an effective tool, not only for controlling costs, but also as a measure for case mix analysis, quality and workload reporting. It has successfully slowed the rate of inflation of hospital cost for the Medicare population by providing hospital management and physicians with the incentive to provide care more efficiently. The fact that most third-party payors adopted the DRGs after the Medicare PPS implementation testify to their diverse capabilities. Department of Defense has started

assignment of DRGs to inpatient records in their direct care system, and some resource allocation within service branches by DRGs have been made. OCHAMPUS also directs that their fiscal intermediaries assign DRGs to CHAMPUS claims for inpatient care, but resource allocations for CHAMPUS inpatient care by DRG has not yet begun.

Payment for ambulatory care in the civilian arena has remained essentially cost based or fee for service. The result has been a large increase in both volume and cost of ambulatory care, which has partially offset the savings achieved in the inpatient setting. Increases in physician payments far in excess of inflation along with the concern about the relationship between charges and the resources expended to provide services has brought about demands for physician payment reform.

In the 1986 Omnibus Budget Reconciliation Act (OBRA), Congress directed that Health Care Financing Administration (HCFA) develop a prospective payment system for ambulatory care. Under this act, facility costs for ambulatory care in settings such as hospital outpatient departments, emergency rooms, same day surgery units, and outpatient clinics would be paid on a prospective basis. Facility costs are those connected with the facility, such as medical and surgical supplies. Physicians' professional services fees would not be included.

One approach to the development of an ambulatory prospective payment system would be to design a system that is similar to the inpatient DRGs. In order to develop such a payment or resourcing system, however, it is necessary to determine a basic unit of

payment. In the ambulatory setting the basic unit of payment has traditionally been the visit, representing a contact between a patient and a health care provider. A visit can be for a diversity of services, all the way from an evaluation of a condition to provision of complex tests and/or extensive use of ancillary services.

Along with the Congressional mandate to develop a PPS for ambulatory care facility payments, the OBRA of 1989 prescribed physician payment reforms that would change the way physicians are paid for ambulatory services. Medicare Title XVIII to the Social Security Act established that physician payments under Part B, or Supplementary Medical Insurance, would be paid by reasonable charge methodology. In general, the reasonable charge is the lowest of the physician's actual charge, the physician's customary charge, or the prevailing charge in the locality for similar services. Medicare's method of paying physicians on the basis of historical charges has distorted the pattern of relative payment across different physician specialties, geographic areas, and services (Physician Payment Review Commission, 1991).

Section 6102 of the 1989 OBRA amended Title XVIII by adding a new section, "Payment of Physician's Services". This section established three major elements: (1) Replacement of the reasonable charge method of payment for physician payments with a fee schedule; (2) Establishment of volume performance standard rates of increase for physician payment expenditures; and (3) replacement of the maximum allowable charge for nonparticipating physicians (Health Care Financing Administration [HCFA], 1991).

The fee schedule would apply to physician services including professional services, services and supplies incidental to physicians' services, outpatient physical and occupational therapy, and diagnostic and therapeutic radiology.

The implementation of a fee schedule, or a resource-based relative value scale, for all specialties is a major change to the way physicians are paid for services. However, a relative value scale has already been implemented successfully for specific areas, such as radiology and anesthesiology (HCFA, 1991, November 25).

When the DRGs were implemented under PPS for Medicare, third party payors immediately began using them also for other populations. DRGs quickly became the "nationally accepted" payment tool for inpatient care. It is envisioned that the same thing will happen in the ambulatory care arena. When HCFA implements a classification system for Medicare ambulatory care, third party payors are expected to follow the precedent set with DRGs and also adopt the systems that HCFA implements. If this happens, then both under CHAMPUS and the direct care system (for contract physicians), payments for services would be negotiated and paid for using the systems implemented for Medicare.

Classification systems for ambulatory care have not been proliferated to date for many reasons. Ambulatory care data have not been collected routinely by clinics or hospital outpatient departments. The sheer volume of ambulatory medical care stresses most current computer systems and negates integration of ambulatory data with inpatient data collection. However, the

shift from inpatient to ambulatory care increases the importance and high priority of ambulatory systems development. This is expected to be an area for growth and attention in all health care information systems.

Use of a case-level classification system for ambulatory care prospective payment could provide many advantages over the current systems. However, if used for resource allocation, it must measure case mix of facilities or providers in order to provide equitable reimbursement. In the current environment of diminishing resources, a classification system should provide the critical information needed to make appropriate choices of the medical services to be provided. Therefore, it is very important that the best systems available be selected for use by DOD as well as by HCFA for the Medicare Program and other large systems.

A classification system should give managers the information needed to understand and control costs. It should encourage provider efficiency and provide important clinical management information. However, a classification system should be implemented so as to continue or increase rather than decrease access to care and quality of care.

A classification system should not be cumbersome to administer. It should have a small number of groups and minimum data element requirements that are routinely collected by most information systems. It should also be comprehensive for all specialties (including ancillary services) so as to be useful throughout the health care industry.

The groups of a classification system should have similar

clinical characteristics. The definition of similar clinical characteristics is dependent upon the goal of the classification system (Averill, Goldfield, McGuire, Bender, Mullin & Gregg, 1990). For APGs, the definition of clinical similarity relates to the rationale for differences in resource use. If, on the other hand, the classification goal was related to patient prognosis, then the definition of patient characteristics which were clinically similar would probably be different.

Because of the volume of ambulatory care provided within the MHSS and the lack of automated systems, data capture and analysis presents even more of a challenge than in the inpatient area. Although no case-level data are currently being collected in the direct care system for ambulatory care, Congress has mandated (Public Laws 99-661, November 14, 1986; PL 100-108, November 4, 1987) that DOD move toward resource allocation for MHSS ambulatory care using a classification system like the DRGs for inpatients. This implementation was to be for Fiscal Year (FY) 1989; however, it has been delayed because of the lack of case-level clinical and cost data in the direct care system.

Within the MHSS direct care system, summary statistics are maintained that report the number of clinic visits to each clinic specialty by beneficiary category. Documentation of a visit is made in the patient's chart; there is no automation of this information. Resources for outpatient clinics are allocated based on the number of visits to each clinic.

This study uses tri-service data, and will have implications for all three military services. An ambulatory data base will be

developed from CHAMPUS fiscal intermediary claims. Encounter records will then be developed from these claims and will be classified using the case-level classification systems Ambulatory Patient Groups (APGs) and Resource-Based Relative Value Scales (RBRVS). Both systems targeted for use are under development; neither have been field tested. Therefore, not only will this study evaluate their applicability to MHSS ambulatory data, but it will also evaluate their use as a tool for analysis, planning, clinical comparisons, and resource allocation. The use of CHAMPUS ambulatory care data in this project will give insight into current and projected utilization of ambulatory services in the CHAMPUS portion of the MHSS, as well as provide helpful information for the direct care system in the absence of current case-level ambulatory data.

The CHAMPUS data base is maintained centrally and contains the fiscal intermediary claims for inpatients, outpatients, and special programs under CHAMPUS. A copy of this data has been reconfigured and used in the Tri-Service CHAMPUS Statistical Database Project (TCSDP) at U.S. Army Health Care Studies and Clinical Investigation Activity (HCSCIA). The CHAMPUS Professional Services Classification Study (CPSCS) will build a data base from these claims that will include all ambulatory visit records for Fiscal Year 1989 (approximately nine million claims), then use these data or a sample thereof for classification into APGs and RBRVS. The data base will be designed using recommendations from the National Committee on Vital and Health Statistics regarding the Uniform Ambulatory Care Data Set (1990), along with

the Washington Business Group on Health and National Association of Health Data Organization (NAHDO) (1989) recommendations for data uniformity and the ambulatory data record. This data base can provide a prototype for the ambulatory data record that will be used when ambulatory data collection is begun in the MHSS direct care system or for future CHAMPUS data system revisions.

Literature Review

There are many ambulatory classification systems available for use, but none currently being used on a national scale. In review of the systems available, there are at least 35 classification systems either in development or that have already been developed (Georgoulakis, Akins, Richards, Guillen, Gaffney, Bolling, Austin, & Moon, 1990). Of the systems available, most are not feasible for use in the MHSS. Some of the systems have been ruled out because the data collection requirements are impractical considering the large volume of data that will be generated within the MHSS direct care system and the resource requirements for data collection. Other systems do not make enough distinction between services to be of value for measuring intensity of illness or resources consumed. Some systems lack documentation or are in a revision process.

In consideration of implementation of ambulatory classification systems within the CHAMPUS or MHSS direct care system, it is generally believed it would be better to be compatible with other agencies (such as HCFA, with the Medicare program) than to have yet another system that Congress would need to become familiar

with. Particular attention was directed, therefore, to the classification research that was currently being funded by HCFA at the time the project was designed.

The systems that HCFA appeared to be most interested in were the Products of Ambulatory Care (PACs), Ambulatory Visit Groups (AVGs), Diagnosis Related Groups (DRGs) (as applied to ambulatory care), and Ambulatory Patient Groups (APGs). Additionally, there was a tremendous lobbying effort going on regarding physician payment reform and consideration of the Resource-Based Relative Value Scale (RBRVS).

As we mentioned earlier, although Diagnosis Related Groups have become the accepted classification for inpatients, there is no nationally accepted ambulatory classification. There have been some efforts to also use the DRGs as a classification tool in the ambulatory setting.

In a study for Health Care Financing Administration, Dr. Joanna Lion applied the DRGs to records of aged Medicare patients seen in hospital outpatient departments, attempting to evaluate use of DRGs as a prospective payment system for ambulatory surgery (Lion, Vertrees, Malbon, Collard, & Mowschenson, 1990). This use of DRGs was rejected for two reasons. Almost twenty percent of the dollar volume of hospital-based ambulatory surgery records fell into medical DRGs rather than surgical. Additionally, the ratio of the inpatient DRG weights to the ambulatory billed charges for the ambulatory DRGs had excessive variation (more than tenfold). It would be very difficult to

apply the DRGs to both inpatient and ambulatory data in a consistent manner.

Margaret Sulvetta (1991) applied the DRGs to Medicare outpatient surgery data. She reported that the DRG system is not appropriate for use as an ambulatory payment system. She further stated that because of its focus on inpatient care, it does not recognize ambulatory surgery procedures as significant procedures.

Products of Ambulatory Care (PACs) were developed under a grant from HCFA by New York State Department of Health (Tenan, Fillmore, Caress, Kelly, Nelson, Graziano & Johnson, 1988). PACs are based on the concept of bundling together all the medical services provided to a patient, except for high-cost technologies, which are separated into different groups. In a study using a sample of data collected from six Army hospitals (Georgoulakis et al., 1990), 57 percent of the data was categorized by three PACs.

The PACS were designed primarily for reimbursement. Therefore, many types of diagnostic conditions are combined into groups requiring similar resources. Consequently, the groups are not as clinically meaningful as some other classification systems.

PACs do not cover ambulatory surgery services. A separate system called Products of Ambulatory Surgery (PASs) was developed for ambulatory surgery (Kelly, Fillmore, Tenan, & Miller, 1990). Margaret Sulvetta (1991) evaluated the PASs as a prospective payment system for ambulatory surgery. Using Medicare data for her evaluation, she found that three PASs accounted for over

half of all claims and nearly two-thirds of all charges.

HCFA has recently funded research for an expansion of the PACs. The 24 medical PACs have been expanded into 71 groups and when combined with the 42 PASs, created a combined system called Products of Ambulatory Care and Surgery (PACS), with a total of 113 groups (H. H. Fillmore, personal communication, January 15, 1992).

Ambulatory Visit Groups (AVGs) were also considered as an alternative approach for ambulatory prospective payment in the Medicare population. Under grants from HCFA, researchers at Yale University developed the AVG patient classification scheme to be similar to the inpatient DRGs. It was envisioned that the combination of DRGs and AVGs could adequately describe a hospital's product (both inpatient and outpatient) and account for variation due to case mix differences (Schneider, Lichtenstein, Fetter, Freeman, & Newbold, 1986).

The AVG groupings are clinically meaningful to providers and clinicians. However, they do have several characteristics that limit their applicability as the unit of payment in a prospective payment system. There are 570 AVGs, an excessive number of classes given that much of ambulatory care is concentrated in only a few types of visits.

The AVGs also utilize patient characteristics in their definition which are not collected on the ambulatory claim form utilized by Medicare, CHAMPUS, or existing ambulatory data systems. Old versus new patient is an example. Other than survey

data such as the National Ambulatory Medical Care Survey (NAMCS) (DeLozier & Gagnon, 1987), we were unable to locate current data that contain this data element. Not only is this data element not generally collected, but there is much confusion as to the definition of a new patient, whether it more appropriate to define a new patient as being new to a provider, new to a group practice, or new for treatment of a new or acute condition.

The first grouping algorithm or decision tree in the AVGs is the principal diagnosis check, where the records are subdivided into Major Ambulatory Diagnostic Categories (MADCs). Because of this structure, the same procedure may be found in multiple AVGs. In some cases it is therefore difficult to describe the services performed using AVG descriptions of groups.

The large number of groups make AVG use prohibitive. Neil Smithline (1990) reported that AVGs classified 72% of worker's compensation cases that had a major surgical procedure into 18 AVGs. Of these 18 AVGs, two accounted for 41% of all outpatient cases.

Dr. Joanna Lion tested the AVGs as a tool for classifying hospital-based ambulatory surgery (Lion, Vertrees, Malbon, Harrow, Collard, & Mowschenson, 1990, February). In this research, the 25 most common AVGs accounted for 80 percent of the dollar volume of ambulatory surgery.

In Margaret Sulvetta's research on ambulatory surgery (1991), AVGs accounted for approximately 62 percent of the variation in charges. However, only 305 of the 570 groups were used.

AVGs are a good measure of case complexity. They are incomplete in that they do not encompass laboratory testing and radiology.

In order to obtain an ambulatory patient classification scheme more suitable for use in a prospective payment system, HCFA in March of 1989 awarded Health Systems, International (now 3M Health Information Systems) (3MHIS) a grant to develop the APGs.

Ambulatory Patient Groups

When 3MHIS began their research on ambulatory patient classification, one of the systems they reviewed in detail was the AVGs. After several months of investigation it was decided that a major departure from the diagnosis-based AVGs to a procedure or service-based system would be more appropriate for ambulatory care.

There are major differences between the AVGs and APGs. The AVGs followed closely the DRG methodology to facilitate linking of the two systems, DRGs and AVGs, for describing the total health care. Both DRG and AVG programs grouped first on diagnosis, and procedures therefore could fall into several different groups, depending on the diagnosis of the patient. In ambulatory care, it is much more common to characterize the care according to the procedures or services performed. Additionally, in the ambulatory setting the service provided is generally thought to be a much better indicator of resource requirements. Therefore, for the procedural APGs, the groupings were based first on

procedure rather than diagnosis. Under this philosophy, each significant procedure would be grouped to only one APG. This would make the definition of the APGs more meaningful to providers of care.

APGs were developed to be used in a wide range of ambulatory settings including same day surgery units, hospital emergency rooms, hospital outpatient clinics and physician offices. They do not address phone contacts, home visits, nursing home services, or inpatient services. APG evaluators for HCFA are using Medicare data, since HCFA's anticipated application of APGs will focus on Medicare patients. However, APGs were developed to represent ambulatory patients across the entire patient population. For example, pregnancy APGs were developed although this would not be encountered in the Medicare population. APG developers contend that APGs can be used to differentiate both facility costs and professional costs, although their anticipated use in the Medicare population will be prospective payment for facility costs of outpatient services (Averill et al., 1990). Professional costs relate primarily to professional time and, therefore, directly impact facility time when the care providers are part of the facility. Dr. Joanna Lion (Lion et al.,1991, September 30) discussed separation of physician and hospital reimbursement as follows:

> While separation of physician and hospital reimbursement is the same principle under which DRGs have been used as a prospective payment system for inpatient hospital care since 1983 (physician fees are excluded from DRGs), the separation is less clear on the outpatient side.

> For procedures, regardless of setting, the issue is fairly clear cut. For example, laboratory tests and radiological procedures have both professional and technical components: a pathologist or radiologist interprets a procedure which has been performed by a technician using expensive equipment. In the same manner, ambulatory surgery has the same division: an ophthalmologist does cataract surgery in an ambulatory surgery setting. There is one fee for the ophthalmologist and a second for the technical component, in this case the hospital outpatient department which provides operating room, anesthesia, and the implantable lens use in the operation.
>
> The distinction is much less clear, however, in a physician's office based setting, where the professional component (the physician's time) and the technical component (his overhead) are difficult to separate. For this reason, the ambulatory patient groups cannot be simply applied to physicians' offices but only to settings where professional and technical components can be distinguished if this rather artificial separation is to be maintained.

This study will not only evaluate use of APGs for facility payments for ambulatory care, but will also examine their application for professional services resource allocation.

There are 297 APGs, as compared to 570 AVGs. This smaller number of groups also makes the APGs more attractive for analysis and resource allocation. A complete list of the APGs can be found at Appendix A.

Resource-Based Relative Value Scales.

The Resource-Based Relative Value Scale (RBRVS) is the work of a research team, lead by Dr. Hsiao, at Harvard School of Public Health. In 1978 their group began development of a relative value scale for medical and surgical services (Hsiao & Stason, 1979).

In the 1980's, as a result of spiraling costs and introduction of prospective payment for inpatient services, attention also began to focus on physician payments and reform. This relative value scale study began to receive national attention, and HCFA's Office of Research and Demonstrations, jointly with the National Institute of Mental Health, supported this study. Other organizations which contributed funding include: Aetna Life Insurance Company, American Association of Oral and Maxillofacial Surgery Educational Foundation, Asthma and Allergy Foundation of America, Blue Cross and Blue Shield, The Commonwealth Fund, The Dermatology Foundation, Equitable Assurance Society of the US, Henry J. Kaiser Foundation, Metropolitan Life Foundation, and the Prudential Foundation. (Becker, Dunn, Braun & Hsiao, 1990). The RBRVS study was designed to develop an alternative method to reimburse physicians for services performed rather than using the Customary, Prevailing, and Reasonable (CPR) charge system which Medicare had adopted. According to Dr. Becker, (1990) the study attempted to demonstrate that relative resource costs of physician services can be measured in a rational and systematic way.

The RBRVS bases payment on the relative resource-input costs encountered by physicians in performing their work. Because the RBRVS system could change the economic incentive structure to physicians, thus affecting the cost, quality, and access of medical services, this study has been widely discussed by all levels of health services researchers and providers.

The Resource-Based Relative Values provide relative values for each CPT-4 procedure. Although they were developed for physician payments, they could also be used prospectively for PPS, resource allocation and budgeting.

RBRVS were developed in two phases, and Phase III was for refinement of Phase I and II work and completion of assignment of values to all CPT-4 codes. The first phase was reported in 1988, and the second phase ended in the summer of 1991. Phase III has been ongoing for the last several months.

The RBRVS reflects estimates of what the relative costs of efficient physicians would be if a perfectly competitive market functioned in the medical environment (Becker, Dunn, Braun, & Hsiao, 1990). After systematic exploration of the factors that physicians identify as constituting their work input and other resource costs, methods to measure these components were developed. A model was developed that defines resource inputs to physicians' services as: 1) the work expended by the physician on particular services, encompassing time spent before, during and after the service, and the intensity with which that time was spent; 2) The practice costs necessary to supply the service; and 3) the opportunity cost of training, which represents the income forgone when physicians pursue additional years of training to be a qualified specialist. These three factors are combined in a multiplicative model to produce the resource-based relative value of a given medical service.

The work of the Harvard team is quite remarkable, but as with any controversial change, it is not without its dissenters.

Questions arose concerning the applicability of visits crossing specialties, the validity of extrapolated values, and the validity of pre- and post-service estimates. Findings from Phase I showed current physician charges are not closely related to resource costs, and that evaluation and management services are compensated at a lower rate relative to resource costs than are invasive, imaging, and laboratory services (Hsaio et al., 1988).

The second phase of the RBRVS research was undertaken to address the shortcomings identified in Phase I and to expand the scope of the study to include 15 additional medical and surgical specialties plus the resurveying of 7 Phase I specialties. In response to Phase I criticism, the team had the technical consulting group panels redefine the identification of services belonging to a family. Additional criteria used to strengthen family homogeneity included "similar technology (or technique) is used in performing the services, services are performed in the same setting, and the services are all performed in the same specialty" (Hsiao et al., 1990). Furthermore, the Harvard team collected additional data to validate the extrapolated values. The data showed that 66 percent of the extrapolated values were within 20 percent of the national survey, 83 percent were within 30 percent, and 17 percent differed by more than 30 percent.

The Harvard team has aligned relative values for 33 specialties on a common scale. The team assembled groups of physician panelists in each specialty and allowed all panelists to vote on accepting or rejecting each specialty link and to rate the quality of the linkage. By the end of Phase II, the team had

developed 5,752 relative values representing over 4,150 CPT-4 codes. These codes accounted for 85 percent of the Medicare dollars (Hsiao et al., 1990).

The RBRVS do not attempt to measure all attributes of physician services. Inputs are considered, rather than outputs, or health outcomes. The RBRVS, in measuring resource inputs, provide a more objective basis for estimating prices than the current reasonable and customary charge methodology. This is not to say that the RBRVS do not have shortcomings. The RBRVS do not take into account the patients' demand for services. According to Becker (1990):

> In a reasonable competitive market, fees for physicians' services would be driven down by competition to the resource costs required to produce these services. Services whose costs exceed patients' *willingness* to pay would not be demanded by patients. While RBRVS may reasonably represent the relative costs of different services, RBRVS-based payment rates for some services could exceed patients' valuation of them. This problem has to be considered if the RBRVS is ultimately used to pay physician services.

Furthermore, the RBRVS is based on the CPT-4 procedure classification, and as such, does not capture severity of patients within a given CPT-4 code. Additionally, assignment of CPT-4 codes may vary from one physician to another, depending on their interpretation of service. However, these shortcomings are to some degree a part of any payment system that uses a uniform fee schedule.

Use of Ambulatory Classification Systems

Although neither of the classification systems being studied are in use currently, it is anticipated that HCFA will begin

using the APGs and RBRVS for facility and physician payments in the Medicare system. The Final Rule for implementation of the Fee Schedule for Physicians' Services (HCFA, 1991, November 25) applies to services furnished beginning January 1, 1992. The RBRVS schedule will be phased in over the period Fiscal Year (FY) 1992 through 1995.

Implementation of a case-level ambulatory classification system within DOD has been Congressionally mandated. It is intended that this study will provide valuable information to policy makers for design and implementation of an ambulatory classification system for the MHSS, as well as give insight into managing the spiraling costs of CHAMPUS health care. Additionally, a data base will be established that can be used for other ambulatory care research, both for CHAMPUS and the MHSS direct care system.

OBJECTIVES

Objectives of the CHAMPUS Professional Services Classification Study are:

1. Classify Fiscal Year 1989 CHAMPUS professional services data into Ambulatory Patient Groups (APGs) and assign Resource-Based Relative Value Scales (RBRVS).

2. Develop a weighting system for APGs and conversion factors for RBRVS.

3. Provide Office of the Surgeon General (OTSG) and other Army and DOD agencies a complete CHAMPUS professional services research data base with APG and RBRVS fields appended.

4. Provide OTSG and other Army and DOD agencies the necessary software and documentation to group future CHAMPUS data efficiently and effectively.

METHODOLOGY

Overview

Secondary data files were used in this study, consisting of claims for professional services processed to completion during FY 1989. These claims were originally processed by CHAMPUS fiscal intermediaries at a regional level, then combined into central files at OCHAMPUS. Copies of the Quick Response Definition Files (QRDF) created at OCHAMPUS were transmitted to this Activity for the Tri-Service CHAMPUS Statistical Database Project (TCSDP). Data for the Professional Services Classification Study were then extracted and represent the ambulatory care, or professional services, claims processed to completion in FY89. These are called "Type 7" records in the QRDF file. These claims represent CHAMPUS beneficiary outpatient visits to hospital outpatient departments, clinics, physicians' offices, same-day surgery units, or any other site outside the direct care system of MHSS but purchased under CHAMPUS.

Data

Files copied from the TCSDP consist of both summary and detail records. Summary records contain demographic information about the patient, the diagnosis or condition being treated, and the payment information for the entire claim. Accompanying each summary record are detail records, which present in detail each service rendered, along with dates of service, source of care, payments made, and other information regarding that particular

service. The summary records extracted for this study comprise a data base of almost ten million records, representing the military services as follows:

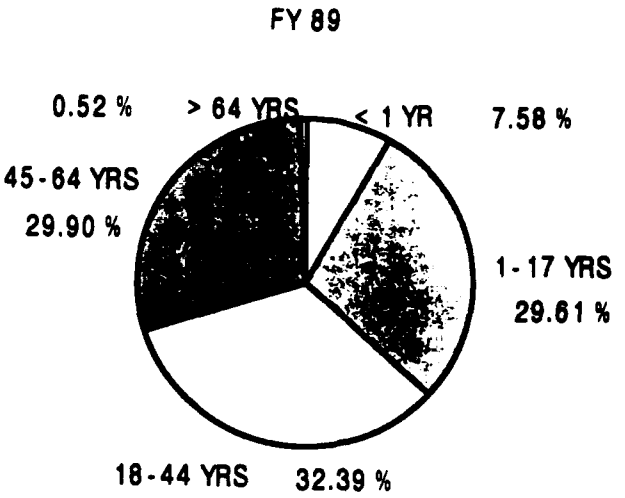
Army	3,206,802 records
Air Force	3,040,271 records
Navy (Including Marines)	3,632,743 records.

Each summary record could have up to 32 detail records. The summary and detail records together represented almost 30 million records. This data base was loaded on to the Fort Detrick Data Processing Center computer at Fort Detrick, Maryland and was remotely processed via communications linking the Fort Detrick mainframe computer and computers at HCSCIA located at Fort Sam Houston, Texas.

From the file extracts outlined above, records were separated into a set of "Goods Files" and a set of "Adjustment Files". The Adjustment Files contain records of all claims that have been denied, cancelled, corrected or adjusted along with good records matching those claims (about twenty percent of the data, most of which were denials). Separation of these adjusted or denial records left 7.8 million summary records in the Goods Files. When these records were combined with their detail records, the final "Goods Master Files" contained 16,526,835 records.

The beneficiaries whose claims for ambulatory care were processed to completion during FY 1989 can be described in several ways. The majority are of the age group 18-44 years (see Figure 1). Approximately sixty-five percent of these are female (see Figure 2). The largest beneficiary category is

Figure 1. Age of CHAMPUS Professional Services Beneficiaries



dependents of active duty personnel (see Table 1). Data shown in Table 1 are categorized by the sponsor's branch of military service.

Figure 2. Gender of CHAMPUS Professional Services Beneficiaries

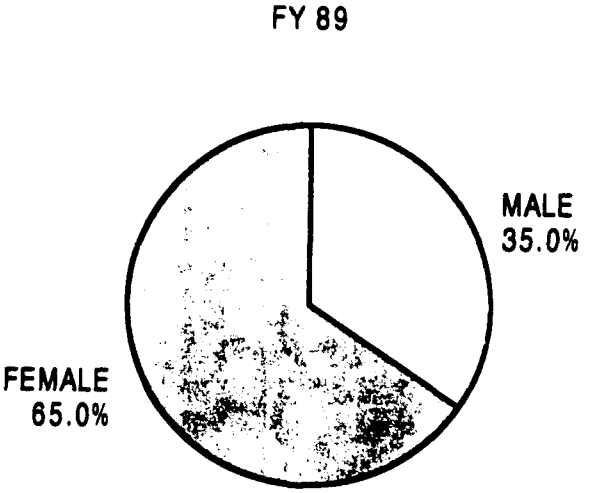


Table 1

Beneficiary Category of Patients by Military Service of Sponsor

MILITARY SERVICE FREQUENCY PERCENT	BENEFICIARY CATEGORY					
	OTHER	DEPN AD	RET MIL	DEPN RET	DEPN DECS	TOTAL
ARMY	2935	358681	91464	199827	26552	679459
	0.15	18.82	4.80	10.48	1.39	35.65
AIR FORCE	2941	226766	105525	200784	20576	556592
	0.15	11.90	5.54	10.53	1.08	29.20
MARINES	491	83842	17271	35127	4162	140893
	0.03	4.40	0.91	1.84	0.22	7.39
NAVY	2034	293426	75283	142862	15478	529083
	0.11	15.39	3.95	7.50	0.81	27.76
TOTAL	8401	962715	289543	578600	66768	1906027
	0.44	50.51	15.19	30.36	3.50	100.00

Note. DEPN AD = Dependents of Active Duty Sponsors; RET MIL = Retired Military; DEPN RET = Dependents of Retired Military; DEPN DECS = Dependents of Deceased Sponsors.

Although each summary record could have up to 32 detail records, the average number of detail records per summary was 2.1. Generally, each summary record represented one claim; however, when claims spanned fiscal years, two summary records were generated. Also, claims were not limited specifically to an episode of care, a service, one source of care, or a time period. One claim might cover care from more than one source, or provider, of care, more than one particular service, or services by one provider on several different dates. Claims were usually for the same medical condition, although the specific five-digit

diagnosis among the different care providers presenting their portion of the claim.

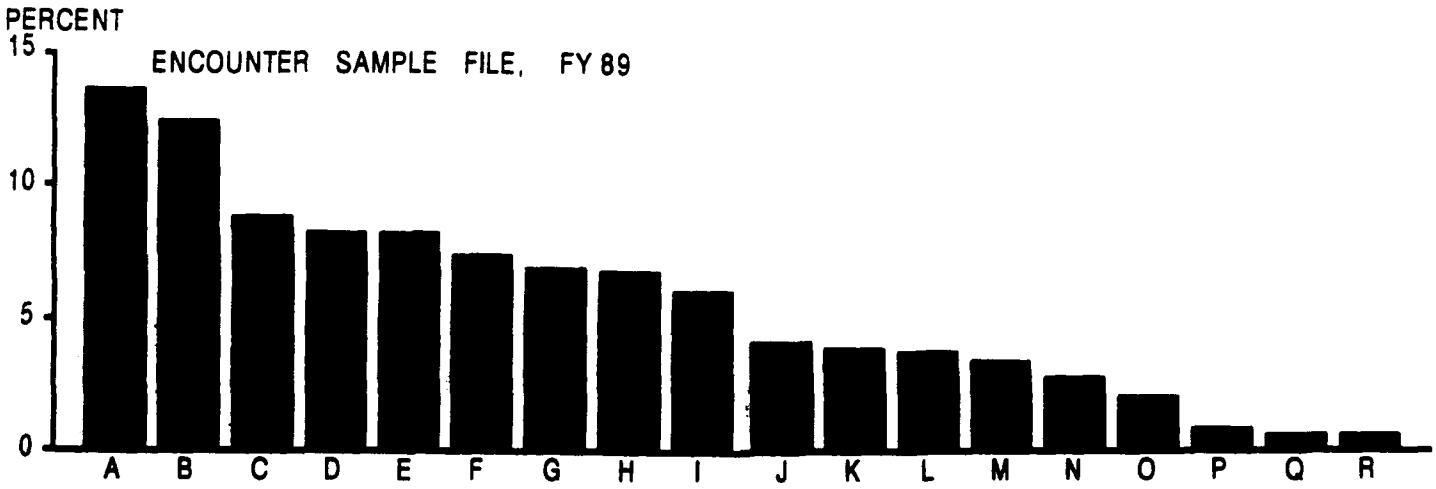
Conversely, a claim might only cover one service provided, with multiple claims for each encounter or each source of care. Although some information can be gleaned from modifiers that are generally attached to procedure or service codes in claims data, these modifiers were not included in the Tri-service CHAMPUS Statistical Database (TCSDP) professional services files nor subsequently in the CPSCS files for this study.

Claims for ambulatory care under CHAMPUS are for a wide variety of conditions. Figure 3 displays the groups of diagnoses that constitute the reason for visit or for services provided for which the claim is made (from the sample file). Diagnoses were coded using International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM) (Health Care Financing Administration [HCFA], 1988). The most frequent condition coded in the sample file was diagnosis code 3829, Unspecified otitis media; followed by 4019, Essential hypertension; 3004, Neurotic depression; and 4779, Allergic rhinitis. These four conditions accounted for almost ten percent of the claims in the sample file. A more complete listing by the highest-frequency three-digit diagnosis categories can be found at Appendix B.

Procedures appearing on the CHAMPUS data files were from Physicians' Current Procedural Terminology Fourth Edition (CPT-4) (American Medical Association, 1988) codes, except for a very small number of CHAMPUS-unique codes created for recording particular services for which there were no appropriate CPT-4

code. The most frequent procedures or services coded in the sample file were the visit codes. There was no real pattern in the coding of visits, however. Sometimes an office visit would be coded with a service, and other times the service would be coded alone, with the charges of the visit included with the service. In the medical cases where no significant procedure was done, it was expected that almost every claim would have a visit coded. However, it turned out that only about 53 percent contained a visit code.

Figure 3. Diagnosis Categories of Professional Services Patients, Encounter Sample File

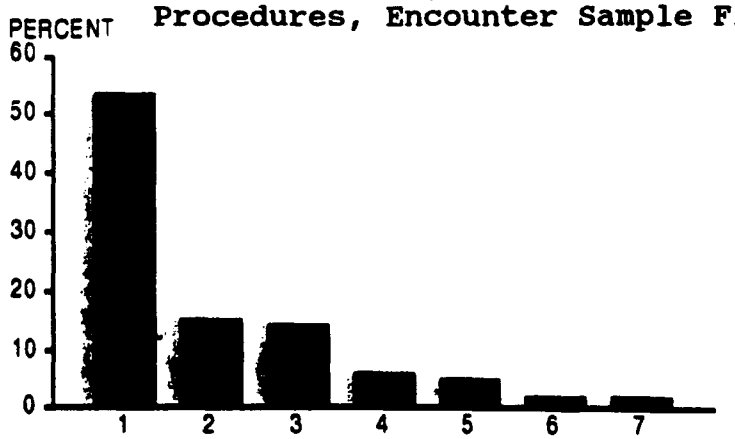


DIAGNOSIS CATEGORIES:

A - MENTAL DISORDERS
B - RESPIRATORY SYS DISORD
C - NERVOUS SYSTEM DISORD
D - SYMPTOMS, SIGNS
E - GENITOURINARY SYS DISORD
F - CIRCULATORY SYSTEMS DISORD
G - MUSCULOSKELETAL SYS DISORD
H - INJURY AND POISONING
I - FACTORS INFLUENCING HEALTH
J - ENDOCRINE, METABOLIC DISORD
K - NEOPLASMS
L - DIGESTIVE SYSTEM DISORD
M - SKIN, SUBCUTANEOUS TISSUE D
N - INFECTIOUS, PARASITIC DIS
O - COMPLICATION OF PREGNANCY
P - CONGENITAL ABNORMALITIES
Q - BLOOD, BLOOD-FORMING ORGANS
R - PERINATAL CONDITIONS

When the frequency of each procedure code was accumulated separately rather than in groups, the procedures having the highest frequency were CPT-4 codes 99070, Special supplies; 90844, Individual psychotherapy; 90050, Office visit, established patient, limited; 90060, Office visit, established patient, intermediate; and 84999, Clinical chemistry test. These five procedures constituted almost one-third of all individual procedures or services provided. Figure 4 displays the major categorie of procedures coded. A listing of selected procedures or services by CPT-4 code and percent of total procedures/services is listed at Appendix C. This list contains all codes that accounted for at least one percent of the total volume of services (16 codes), and when the percents are summed, accounts for fifty percent of the total services provided.

Figure 4. Procedure Categories of Most Frequently Coded Procedures, Encounter Sample File



CPT-4 PROCEDURE CATEGORIES:

1 - All procedures not categorized in following categories
2 - Office Visits
3 - Special Supplies
4 - Individual Psychotherapy
5 - Chemistry/Blood/Urine Tests
6 - Radiographic Procedures
7 - Emergency Care

Development of Encounter Files

Before classification of the data, it was necessary to determine a unit of service upon which to base the classification. There is not a wealth of ambulatory data available, but most of that which was reported is visit-based. Although it would be desirable for managed care and capitation applications to have data aggregated as episodes rather than visits, research is still in its infancy as far as definition of episodes, except for a few conditions.

After considering several alternative approaches, project members decided to create "Encounters" as the unit of service for this study. An Encounter is defined as all care provided on a particular "care begin date", whether received from one or multiple claims, for multiple services, or from multiple sources of care. Records from the Goods Master files were reconfigured into Encounter files based on beginning date of care. This again decreased the size of the files to approximately 54 percent of the Goods Master files, or just over 9 million records for the three military services.

By combining all visits and services provided to a patient on one day, it is possible to make comparisons of services performed for a condition by different providers or sources of care. By aggregating these services provided on a particular date of care, however, we expect in a few cases to be combining services when they were in fact provided for different conditions. We expect this will be balanced to some degree by the ancillary services that are provided on the day following the visit which

actually should have been linked to the visit of the previous day. Although there are exceptions, research indicates that for ambulatory care, the majority of ancillary services are provided on the same date as the visit or the surgical procedure. By combining the ancillary services with the visit and surgery data into encounters, the variance attributable to place of care can be studied.

It is believed that services provided for treatment of a condition should generally require the same resources, whether they are provided in a doctor's office, hospital outpatient department, laboratory, x-ray department, or same-day surgery unit. However, it is recognized that practice expense varies by site of service; because of different programs, recovery of costs vary according to the program for a particular site of service. Hospital outpatient departments include certain facility charges, whereas doctor's office practices have different overhead and other elements of costs. By using the Encounter files, we will be able to investigate the influence that site of service has on costs in the CHAMPUS data.

Data elements selected for the Encounter files were those required for grouping to APGs or assignment of RBRVS, along with other variables required for further research regarding site of service or regional differentials, weight development, or case mix analysis. A description of the Encounter file can be found at Appendix D. While this file will be useful in determining the data element requirements for an ambulatory care data base for the direct care system, it is not to be inferred that all the

fields contained in the Encounter files should be collected. Certainly a data base containing that many data elements would be much too cumbersome for administering, editing, and controlling. It was a difficult data base to work with because of its size and complexity. Conversely, the more simplistic the data base, the easier the data collection and processing would be.

Finally, a two percent random sample was drawn from the Encounter files to facilitate the classification analysis. Records were selected based on the last two digits of sponsor's social security number; these two digits were randomly chosen to create a representative sample.

Mapping, or Recoding, of Diagnoses

Diagnoses were coded using International Classification of Diseases, 9th Revision Clinical Modification (ICD-9-CM). Codes in this classification range from three to five digits in length. Although space for five digits was allowed for in the QRDF files, only the first four were included in almost all of the professional services data received by this Activity. The only category that had five-digit codes reported was the mental health section, and this category was only partially coded with the five-digit codes. This presented a challenge as far as classification of data to APGs was concerned, since the APG software looks for specific five-digit diagnoses codes and considers a four-digit code invalid if a five-digit expansion exists in the classification for that category. This was overcome, however, by development of a crosswalk and mapping the four-digit diagnosis

categories that had valid five-digit expansions.

There were 1,230 four-digit codes for which a five-digit code was available. As a matter of interest, there were 6,426 five-digit codes available for mapping from the 1,230 four digit codes. Many of these were not used at all in the CHAMPUS data. From a set of test data used for map development, the frequency found in these 1,230 codes constituted 30.7 percent of the test data file.

The selection of the appropriate five-digit code was primarily based on the frequency of diagnoses found in the National Ambulatory Medical Care Survey (NAMCS) Patient Visits 1985 (DeLozier & Gagnon, 1987). From the set of test data used for map development, 89 percent of the diagnosis codes requiring mapping could be mapped using the NAMCS frequencies.

If a particular code had no frequency in the NAMCS data, then the following general guidelines were followed for code assignment:

a. If several options were available, particularly those designating body parts, the fifth digit for "unspecified" was selected.

b. For the pregnancy and delivery codes, the fifth digit specifies the episode of care; i.e., delivered, antepartum, or postpartum. For those categories the classification chapter subtitles were followed. For example, the subtitle for the section of codes 640-648 is "Complications Mainly Related to Pregnancy". For those codes, the fifth digit 3, meaning "ante-partum condition or complication" was selected. For the

section that is not used consistently to designate the episode of care in pregnancy and delivery, (Normal Delivery, and Other Indications for Care in Pregnancy, Labor, and Delivery, codes 650-659), the delivery fifth digit "1" meaning "delivered, with or without mention of antepartum condition" was selected.

c. For some categories where no "unspecified" subcategory was available, the first listed fifth digit was selected. The logic for this decision was that a general principle in taxonomy is the arrangement of groups and subgroups by frequency of occurrence.

Mapping of the diagnoses worked very well in creating a file with valid codes that the APG Grouper could recognize, while at the same time not altering the data to influence APG assignment. As a matter of interest, only in a small percentage of the diagnosis codes does the fifth digit made a difference in APG assignment. However, where the fifth digit is particularly important is in the identification of the codes for APG 827, Major signs, symptoms and findings (R. Averill, personal communication, January 17, 1992). None of the RBRV assignments were affected by diagnosis mapping, since their assignment is based solely on CPT-4 procedure codes.

The original diagnosis codes were maintained in the records, and the recoded diagnoses were added as additional fields. The diagnosis crosswalk is attached as Appendix E. The diagnosis mapping will again be validated when case mix reports are generated. In a previous study where mapping of diagnoses were involved, the case mix reports, although generated for assessment

of hospital performance, proved to be an invaluable tool for mapping evaluation (Baker, Austin, & Clay, 1987).

Mapping, or Recoding, of Procedures

Procedures appearing on the CHAMPUS data files were from Physicians' Current Procedural Terminology Fourth Edition (CPT-4) (American Medical Association, 1988) codes, except for a very small number of CHAMPUS-unique codes created for recording particular services for which there were no appropriate CPT-4 code. Since neither the APG classification software nor the RBRVS algorithm would recognize these CHAMPUS-unique codes, they had to be converted to valid CPT-4 codes in order to be useful in the classification process.

There were 130 CHAMPUS-unique codes for which mapping was required. Of these, only 49 were used in the CHAMPUS sample data, and the frequencies in these 49 codes constituted only 9.8 percent of the total CHAMPUS procedures or services in the sample data file.

Additional procedure mapping was done to provide for codes that appeared in the data but had been deleted, added, or changed in the CPT-4 classification. The year of the classification edition used in the APG grouping software was 1989, but the FY89 data file contained claims from FY87 through FY89 that were processed to completion during FY89. These code inconsistencies were also provided for in the procedure crosswalk.

The original procedures coded were maintained in the record, and additional fields were appended for the recoded procedures.

A copy of the procedure crosswalk or translation table is attached as Appendix F.

In addition to the procedure crosswalk, some recoding was done prior to assignment of RBRVS. New codes are being added for physician visits, and the values appearing in the RBRVS were for the new codes. The computer program for assigning the RBRVS to procedures contains the mapping from the old to the new visit codes. A copy of this table is included as Appendix G. These recoded values were not added to each record, since the old visit codes in the record were the ones required for APG groupings.

Limitations of the Data

We have already talked about the CHAMPUS-unique procedure codes, the four-digit diagnosis codes, and the requirement to map these. Analysis of the financial data also must recognize certain assumptions. The most important one is that the CHAMPUS claims were generally expected to have been paid based on the lowest amount of billed charges and prevailing rates. These rates have been computed on historical data and are the amounts allowed for payments of services, unless there is a program or policy governing a claim payment that would take priority over payment by prevailing rates.

Payments under the Partnership Program are an example of this payment exception. Under the partnership program, both external and internal, rates are negotiated between the "Billable MTF' or hospital with financial responsibility for the claim, and the provider of care. For this reason, one cannot assume that

the rates represent true costs or free market prices, since prevailing rates have been established using historical data as a basis of formulation, and since many claims were not even paid based on prevailing rates. Examination of the data revealed that many claims were paid under various programs and demonstration projects. Table 2 displays the categories of programs under which the claims were adjudicated, listed by billable medical treatment facility (MTF) branch of service.

Table 2

Claims for Payment Under Special Programs, by Military Service of Sponsor

SPONSOR'S BRANCH OF SERVICE FREQUENCY PERCENT	CHAMPUS SPECIAL PROGRAMS						
	PARTNER-SHIP PROGRAM, INTERNAL	PARTNER-SHIP PROGRAM, EXTERNAL	NORMAL	MEDICAID	COOPERA-TIVE CARE PROGRAM	HOME HEALTH	TOTAL
ARMY	143387	13	520357	1668	1152	6	666583
	7.64	0.00	27.71	0.09	0.06	0.00	35.50
AIR FORCE	91222	2	457841	585	2466	3	552119
	4.86	0.00	24.38	0.03	0.13	0.00	29.40
MARINES	9048	0	129990	278	317	3	139636
	0.48	0.00	6.92	0.01	0.02	0.00	7.44
NAVY	40153	2	477281	698	1301	8	519443
	2.14	0.00	25.42	0.04	0.07	0.00	27.66
TOTAL	283810	17	1585469	3229	5236	20	1877781
	15.11	0.00	84.43	0.17	0.28	0.00	100.00

One other data limitation that should be mentioned was the absence of revenue codes or modifiers for the procedure codes. These revenue codes are very important in the processing of

claims by fiscal intermediaries, since they furnish important data, particularly information on site of service. These revenue codes are included in the CHAMPUS inpatient data, but it is not known whether this is centrally collected for professional services. We only know that it is not part of the data furnished in the QRDF file and is therefore not a part of the study data base.

Data Processing

Data processing was accomplished using an IBM-3090 mainframe computer located at the data processing center at Fort Detrick, Maryland. The programs used for processing were for the most part written in Statistical Analysis Software (SAS). Personal computers were also used for program development and testing and for processing subsets of the data.

Because of the size of the files, tape or cartridge storage was generally used, with the main data base being stored on direct access devices. When complete files were being processed, many times the processing had to be done in steps because of the tremendous work space requirements. The programmers for this project deserve much credit for the ingeneous methods devised to process the large files efficiently.

For APG grouping, APG assignment algorithms are incorporated into a computer program called the APG Grouper. This program uses several subroutines and table lookups for APG assignment. APG assignment is very similar to the Diagnosis Related Group (DRG) assignment process for inpatient data. However, one major difference is that while only one DRG was assigned an inpatient

record, multiple APGs are assigned visit records, depending on the number and type of services performed.

A magnetic tape containing the APG software programs was provided by 3M Health Information Systems and was loaded onto the Fort Detrick Data Processing Center computer. Accompanying the tape was the notebook version of Ambulatory Patient Groups Definitions Manual Version 1.0 (Averill, Goldfield, McGuire, Bender, Mullin, Gregg, & Steinbeck, 1991). The APG software did not have a general use driver program; therefore, one was written in COBOL to return the desired information from the APG grouper program.

The APG grouper required sequential flat files as input. Since the CHAMPUS professional services files had been created as SAS files, a copy was reconfigured for classification to APGs. Only the data elements required for the grouping process were extracted from the SAS files. Data elements required for grouping are Age and Gender of Patient, Discharge status or disposition, Date of Service, Date of Birth, Diagnosis(es) and Procedure(s). The grouper program would accept up to 27 diagnoses and/or procedures. However, the encounter files were created to contain only up to seven of each. For claims having more than seven procedures or services on a given care begin date, additional encounter records were created with a multiple flag to indicate a set of multiple records.

The APG Grouper software was evaluated for the developers as a by-product of the APG processing for the study. The software

was found to be very efficient, with only very minor changes recommended (Austin, 1991).

For RBRVS assignments, a data file received from HCFA was used that contained the table of RBRVS that appeared in the Federal Register Final Rule (HCFA, 1991a, November 25). These were matched with CPT-4 procedures in the sample file using SAS programs. Additional programming recoded visit procedure codes to the new ones contained in the RBRVS table.

RESULTS

This research has shown that CHAMPUS professional services data can effectively be classified to Ambulatory Patient Groups and be assigned Resource-based Relative Values. Encounter files can be developed from claims data. Additionally, a sample data base has been created that will be amenable to analysis and can be used for further research. Computer programs have been written for forming the data base, developing Encounter files, classifying the data to APGs, and assigning Resource-based Relative Values.

DISCUSSION

Ambulatory Patient Groups (APGs)

APGs were designed to explain the amount and type of resources used in an ambulatory visit (Averill, 1991). Patients in each APG are expected to have similar clinical characteristics and similar resource use and cost. Every patient will not be identical in each APG, but the level of variation should be predictable. Therefore, while the exact resource use of a particular patient cannot be predicted by knowing to which APG he belongs, the average pattern of resource use of a group of patients in an APG can be predicted.

Patients in each APG should also have similar clinical attributes. All available patient clinical characteristics which would be expected to consistently affect resource use are included in the APG definition. Because of this requirement for clinical homogeneous groups, there were more groups formed than would have been necessary had the APGs been developed for explaining resource use alone.

The data elements used to define APGs were limited to the information routinely collected on the Medicare claim form. Diagnoses (coded in ICD-9-CM), procedures (coded in CPT-4) together with age and sex of the patient are the variables used for grouping to APGs. Additionally, the grouper software uses Disposition of patient, date of service, and patient date of birth for editing grouping conditions.

Restricting the patient characteristics used in the definition of the APGs to those readily available insures that the APGs can be used as the basis of an ambulatory prospective payment system. Creating APGs based on information that is only collected in a few settings or on information which is difficult to collect or measure would have resulted in a patient classification scheme with limited applicability.

As mentioned previously, the initial classification variable in both DRGs and AVGs is principal diagnosis. The principal diagnosis is used to classify patients into a set of mutually exclusive Major Diagnostic Categories (MDCs). Within each MDC, procedure, age and complication and comorbidities are used to complete the patient classification scheme. APGs instead use a slightly different approach, i.e., the procedure is the initial classification variable. In the Final Report on the APGs (Averill, et al., 1990), developers explained their reasons for choosing procedure as the first classification variable:

> When a significant procedure is performed in an ambulatory setting, it is normally the reason for the visit. The procedure will normally be scheduled in advance and consume the vast majority of resources associated with the visit.
>
> With procedure as the initial classification variable, each procedure will be assigned to only one APG. With principal diagnosis as the initial classification variable, the same procedure could be assigned to many different APGs depending on the MDC of the principal diagnosis. Having each procedure in only one APG reduces the number of APGs and simplifies the establishment of prospective prices.

There are several RVU (RVU) scales available for CPT-4 procedures. With procedure as the primary classification variable, the RVU scales can be used directly in the formation of the initial procedure classes.

The CPT-4 procedures were combined into four groups, defined as significant outpatient procedures, minor outpatient procedures, incidental outpatient procedures, and ancillary procedures. These groups are mutually exclusive and exhaustive, and were based on whether or not the procedure is normally scheduled, whether it constitutes the reason for the visit, and whether it dominates the time and resources expended during the visit. (See Appendix H for definitions of the four type of procedure categories.) Procedures believed to be performed only on an inpatient basis were excluded from the APG groupings. Patients with a significant ambulatory procedure are assigned to procedure APGs, while those with only minor, incidental and ancillary procedures are assigned to medical APGs.

Body systems were used by the APG developers to form groups of procedures. The procedures in each body system generally correspond to a single organ system and are associated with a particular medical specialty. This grouping methodology is similar to the DRG and AVG groupings, but there are also major differences. One example is the body system for skin and subcutaneous tissue. In the APG algorithms, this includes muscle, whereas muscle is in the musculoskeletal Major Diagnostic Category for DRGs and AVGs. The body systems for the significant ambulatory procedures are shown in Table 3.

Table 3

Significant Procedure APG Body Systems

Category	Description
1	Skin, subcutaneous tissue and muscle
2	Breast
3	Bones, joints and tendons
4	Respiratory, nose, throat and mouth
5	Circulatory
6	Lymphatic
7	Digestive
8	Urinary
9	Male reproductive
10	Female reproductive
11	Nervous
12	Eye
13	Ear

Once each significant ambulatory procedure was assigned to a body system, the procedures in each body system were further categorized by clinical attributes. The classification variables considered in the formation of the procedure classes were: site (face, hand, etc.); extent (excision size: 2 cm. vs. 20 cm.); purpose (diagnostic or therapeutic); type (incision, excision or repair); method (surgical, endoscopic, etc.); device (insertion or removal); medical specialty (urology, gynecology, etc.); and complexity (time needed to perform procedure).

In general, method was used as the primary classification variable for the significant procedures. It was recognized that different methods (such as surgery, endoscopy, manipulation, dilation, catheterization, laser or needle) often require different types of rooms, equipment, supplies, and amount of time required to perform the procedure.

The process of forming procedure groups resulted in 145 significant procedure APGs. Each significant CPT procedure code is assigned to a single procedure APG. If a patient has multiple procedures, then the patient may be assigned to multiple APGs. If the procedures are all in the same APG, then only one APG is assigned the patient. If there are procedures in different APGs, then an APG exclusion list is used to determine if multiple APGs will be assigned. For example, if there are two procedures performed, and one procedure is assigned to the APG for simple skin incisions and the second procedure is assigned to the APG for complex skin incision, then the patient will be assigned only to the complex skin excision APG.

The APG exclusion list identifies, for each APG, other APGs that can be performed with relatively little additional effort and, therefore, do not significantly increase resource use. For example, complex skin incisions exclude both simple skin excisions and nail debridement APGs. Conversely, unrelated procedures are not excluded by the APG exclusion list. For example, the treatment of a closed fracture and the suturing of a skin lesion would result in two APGs being assigned to the patient. The assignment of multiple APGs to a patient is in contrast to procedure DRGs and AVGs which assign a patient to a single procedure DRG or AVG based on a procedure hierarchy that is associated with the MDC of the patient's principal diagnosis.

If all cases of multiple procedures were assigned to a single APG, then there would be an incentive to have patients make separate visits for each procedure. The assignment of

multiple APGs, when appropriate, reduces the financial incentive for multiple visits.

Medical APGs describe patients who do not have a significant procedure performed but receive other medical services during the visit. While the treatment for significant procedures is usually very precise, the treatment received under the medical APGs can vary substantially according to the condition being treated and the severity of the illness. The medical APGs are also grouped on body systems, lending clinical homogeneity to the groupings. The medical APGs are based on ICD-9-CM diagnosis codes. Classification variables used in forming the medical APGs were etiology (trauma, malignancy, etc.), body system, type of disease (acute or chronic), medical specialty, patient age (pediatric, etc.), and complexity (time needed to treat patient). Patient type (old vs. new) was considered as a possible variable; however, that variable was not used since there is difficulty in establishing a precise definition for new patient, the impact on resources of whether a patient was new or established would be expected to vary by setting, and the data element new vs. established patient is not currently collected on the claim form. There were a total of 80 medical APGs formed.

Medical patients are initially divided into the following subgroups based on the etiology of the patient's disease: Well care and administrative, Malignancy, Trauma, Poisoning, Mental diseases, Alcohol and drug abuse, Pregnancy, Neonate, and Other etiology.

In addition to the significant procedure and medical APGs, there are 23 laboratory, 20 radiology, 2 pathology, 1 anesthesia, 15 ancillary tests and procedures, 8 incidental procedure, and 3 chemotherapy drug APGs. These APGs normally do not constitute the reason for the visit but do represent an additional cost.

Application of APGs to CHAMPUS PSCS Data

The sample file of 176,868 encounters was grouped to Ambulatory Patient Groups. The grouper assigned an APG for every CPT-4 procedure code, in addition to assignment of a medical APG for those encounters classified as medical. There were 130,010 encounters, or 73.5 percent, assigned a medical APG. Encounters containing a significant procedure APG did not have a medical APG assigned, although they often also had ancillary APGs assigned.

Most of the APGs were used in the grouping process. Table 4 shows the APGs that had zero frequencies in the initial grouping process. There were several reasons why these APGs were not used.

In some APGs, CHAMPUS fiscal intermediary payment policies affected the data and consequently the assignment of APGs. For example, CHAMPUS directs that the anesthesia codes 00100-01999 and 99100-99140 from CPT-4 not be used, but rather that anesthesia charges be reported under the surgical procedure code with the provider specialty coded as anesthesiology or anesthetist, as appropriate.

Some APGs were not used because of the mapping algorithms used for procedures. The maps were developed using 1990 CPT-4

codes, but the software was written using the 1988 revision of CPT-4 that applied to coding of data beginning January 1, 1989 (Barbara Steinbeck, personal conversation, 1991, May 22). This difference explained the absence of encounters in APG 131, Chemotherapy by infusion. There were almost five hundred encounters in the data, but they had been mapped to the new procedure codes rather than the ones required by the grouper software.

Table 4

Ambulatory Patient Groups With Zero Frequencies, Initial Grouping, CHAMPUS Sample Encounter File

APG	TITLE
131	Chemotherapy by infusion
347	Hyperthermia
365	Anesthesia
500	Class I chemotherapy drugs
501	CLASS II chemotherapy drugs
502	CLASS III chemotherapy drugs
602	Prostatic malignancy
603	Lung malignancy
631	Head and spine injury
654	Individual support trmt. for senility, dementia, ment. ret.
656	Comprehensive psychiatric evaluation and treatment age > 17
657	Comprehensive psychiatric evaluation and treatment age 0-17
658	Family psychotherapy
659	Group psychotherapy
664	Comprehensive therapy for drug abuse with mental illness
669	Family therapy for drug abuse
670	Group therapy for drug abuse
676	Neonate and congenital anomaly
691	Routine prenatal care
693	Routine postpartum care
694	Maternal postpartum complication
723	Sexually transmitted disease in males
736	TIA, CVA & oth cerebrovascular events
751	Cataracts
827	Major signs, symptoms and findings
872	Obesity
932	Aids related complex & HIV Infection with complications
946	Adult medical examination
948	Counseling
950	Repeat prescription

APGs 500 through 502 are for Chemotherapy drugs, classes I, II, and III. Although CHAMPUS does have data for those APGs, they are not included in the professional services data used for this study. There are separate files for drugs in the Triservice CHAMPUS Statistical Data Base.

Many of the visit encounters received the error APG 999, with an error code indicating that a visit code was not found. Although these encounters did have a visit coded, a search of the Definitions Manual revealed that the code '90000', for "Office Medical Service, new patient, brief service" was the only visit code included in the APG software to satisfy the visit code requirement for medical APG assignments.

To determine whether the records containing a visit code would have grouped properly had they been coded "90000' for the visit, the data were adjusted by adding a procedure code "90000" for any record containing visit codes 90010 through 90699. A second pass of the data was made, and this time only 10 APGs had zero frequencies. Table 5 shows the APGs with zero frequencies in the second pass of the data, and the reasons for nonassignment to those APGs.

Analysis of these APGs revealed that for mental health visits to group to the mental health APGs, they also needed the "90000" visit code. The procedure codes in the CPT-4, 908xx series were used in the data for mental health visits. These ranges of codes were not included in the adjusted processing when the additional '90000' visit code was added to the data.

By further adjusting the data to include the '90000' visit code for mental health visits and APG 950 (Repeat Prescription), changing the CPT-4 codes from the 1990 version to the 1989 version, and retrieving the drug data from additional files, all of the APGs would be used except two. APGs 347, Hyperthermia, and 365, Anesthesia, would remain empty for lack of data.

Table 5

Ambulatory Patient Groups With Zero Frequencies in Adjusted CHAMPUS Sample Encounter File

APG	TITLE	REASON FOR ZERO FREQ.
131	Chemotherapy by infusion	1990 CPT codes in data; 1989 CPT codes in grpr.
347	Hyperthermia	True zero frequency in data.
365	Anesthesia	Zero frequency in data; anesthesia costs coded using surgical procedure code.
500	Class I chemotherapy drugs	Not included in data files used.
501	CLASS II chemotherapy drugs	Not included in data files used.
502	CLASS III chemotherapy drugs	Not included in data files used.
664	Comprehensive therapy for drug abuse with mental illness	Did not have '90000' visit code.
669	Family therapy for drug abuse	Did not have '90000' visit code.
950	Repeat prescription	Did not have '90000' visit code.

As mentioned earlier, there are many valid CPT-4 codes for visits, but the Grouper software was written to only recognize the 90000 as a valid visit code. Discussions with APG developers revealed that this code was a "place holder" until the appropriate range of visit codes could be agreed upon by developers and Health Care Financing Administration investigators (B. Steinbeck, personal communication, 1991, May 22). It is recognized that there is extreme variability in the coding of visits, and that this problem must be addressed as part of the physician payment reform initiative currently taking place. The ambiguity and lack of precise definitions in the visit codes used during the period of the study data allowed for erroneous "upcoding" of visits for inexperienced coders or unscrupulous providers. Even experienced coders and providers sometimes have difficulty in selection of codes for visits.

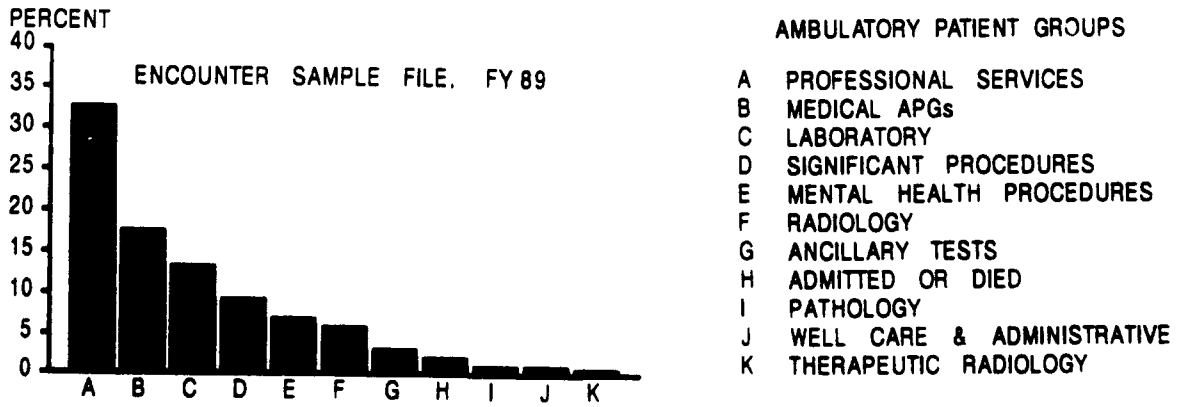
At any rate, rather than have a large number of "ungroupable" encounters with the error APG 999 assignment, it was decided to adjust the sample data by adding an eighth procedure code '90000' to every encounter that had a visit already coded. This adjustment enabled the data to be grouped by the software according to the schematics in the Definitions Manual.

Appendix I contains a complete listing of the APG frequencies from both the initial and the second APG assignments. The "FREQ" and "PERCENT" columns show the results of the first grouping of the data. The last two columns, ADJUSTED FREQ and PERCENT, show the frequencies after the "90000" visit code was added for encounters that had a visit code 90010 through 90699 coded.

The number of procedures that were ungroupable (APG 999) decreased from 27.8 percent to 12.3 percent. It was decided that expansion of the range of codes to include mental health visits for assignment of the "90000" visits would be necessary to further decrease ungroupables.

It is important to note here that the percents shown in the table at Appendix I apply to the individual procedures and not to encounters. In many cases an encounter was assigned a "999" for a medical APG, but received a good APG for the procedural APGs. The frequency distributions in Appendix I are the sum of all APGs on the encounters. For encounters having a medical APG assigned, each encounter also has one APG for each CPT-4 code on the encounter. Those encounters containing procedure or ancillary APGs without a medical APG would have the same number of APGs assigned as the number of procedures coded. Figure 5 shows the frequencies of categories of APGs when all medical and procedural APGs are aggregated, prior to any consolidation or ancillary packaging.

Figure 5. APG Category Frequencies Prior to Consolidation and Ancillary Packaging



Both the medical and procedural APG 999's (error APG) were reviewed. After the final APG grouping there were 17,870 records that had either a medical or procedural APG of 999. Many of the encounters also had valid APGs assigned for other procedures on the same encounter. There were 3,166 encounters, or 1.79 percent of the sample file, that did not have either a valid medical or procedural APG assigned.

The major reason for assignment of the APG 999 error was for inpatient procedures. In the grouping, software procedures are checked against a table of procedures that are considered "inpatient procedures", and if they find a match they receive the APG 999. The majority of the procedures in the sample encounter file that received APG 999 with the inpatient procedures error were for critical care, for Cesarean Sections, or for visits to hospital or skilled nursing facilities. Hospital or skilled nursing facility visits constituted approximately 80 percent of the inpatient procedure errors. Some of the Cesarean Section codes include antepartum and postpartum care; therefore, a portion of the claim was for ambulatory care although the specific procedure is usually done on an inpatient basis.

The hospital visit codes possibly should be deleted from the inpatient procedures list. If the new physician fee schedule being phased in for Medicare covers professional services performed in office settings, and if APGs are used for facility payments, then hospital outpatient department visits probably should receive an APG and be paid under facility payment guidelines. Under the current APG algorithms they do not group to the

proper APG but receive the APG 999. Therefore under current methodologies they could not be paid under either system.

The significant procedure APG assignment takes place as the first part of the grouping algorithm. Therefore, there are no significant procedure APGs on records assigned a medical APG.

In the sample file there are sixty-four APGs used on medical APG records that are from the ancillary and incidental procedure APG list. In fact, the only ones from those categories not appearing on medical APGs were APGs 343, 344, 347, 365, 418, and 500-502. APGs 343 (Therapeutic nuclear medicine by injection), 344 (Radiation therapy), and 347 (Hyperthermia) are radiological APGs that are treated as significant procedures by the grouper algorithms. APG 418 is a laboratory procedure (human tissue culture). APGs 500-502 are the chemotherapy drug APGs mentioned earlier that are not found in the study data.

Some of these APGs did have frequencies on other than the medical APG records; that is, they were either used with significant procedure APGs, other incidental or ancillary procedure APGs, or used alone on a record. Therefore, APGs were assigned before the medical groupings took place.

Just as in inpatient coding under DRGs, there must be some mechanism for recognizing upcoding or fragmentation, or situations when multiple codes are used for component parts of a procedure rather than the appropriate single encompassing procedure code. Two sets of variables are returned by the grouper software to help remedy this problem. A consolidation flag indicates the procedures that are recommended for consolidation

with other procedure codes in the encounter. An ancillary packaging flag indicates for every ancillary procedure whether that service should be packaged with other services being provided.

Application of the consolidation and packaging flags reduces the APG frequencies, even eliminating some APGs completely. For example, by applying the consolidation flag, all professional services visits, APG 469, would be consolidated with other APGs, and APG 469 would have zero frequency. A final APG frequency was compiled by applying both the consolidation and the ancillary packaging flags. This frequency is portrayed in Appendix J, and this listing more realistically describes the grouping to APGs. Table 6 shows the highest frequency APGs after consolidation.

Table 6

Highest Frequency APGs after Consolidation and Ancillary Packaging

APG	APG TITLE	COUNT	FREQUENCY
54	PHYSICAL THERAPY	2780	1.50
351	PLAIN FILM	7457	4.02
426	SIMPLE CHEMISTRY TESTS	3241	1.75
436	SIMPLE HEMATOLOGY TESTS	2655	1.43
633	FRACTURE, DISLOCATION AND SPRAIN	2934	1.58
655	PSYCHOTROPIC MEDICATION MANAGEMENT AND B	3664	1.97
656	COMPREHENSIVE PSYCHIATRIC EVALUATION AND	8104	4.37
657	COMPREHENSIVE PSYCHIATRIC EVALUATION AND	4377	2.36
767	ACUTE INFECTIOUS EAR, NOSE AND THROAT DI	4063	2.19
768	ACUTE INFECTIOUS EAR, NOSE AND THROAT DI	10515	5.67
769	ACUTE NONINFECTIOUS EAR, NOSE AND THROAT	4089	2.20
781	EMPHYSEMA, CHRONIC BRONCHITIS AND ASTHMA	2674	1.44
797	HYPERTENSION	4140	2.23
800	CARDIOVASCULAR DISEASE EXCEPT CHF,ISCHEM	2656	1.43
817	OTHER GASTROINTESTINAL DISEASES	3047	1.64
842	MUSCULOSKELETAL DISEASES EXCEPT BACK DIS	6023	3.25
860	OTHER SKIN DISEASES	5584	3.01
916	FEMALE GYNECOLOGIC DISEASE	3906	2.10
947	WELL CHILD CARE	2504	1.35
951	NONSPECIFIC SIGNS & SYMPTOMS & OTHER CON	3716	2.00
959	ADMITTED OR DIED	13796	7.43

The mental health groupings under the incidental procedures were subsumed by the medical mental health APGs when the consolidation and ancillary packaging flags were applied. The incidental mental health APGs were assigned based on the presence of a procedure code from the CPT-4 Psychiatry section (908xx series). This is really an intermediate step prior to assignment of a medical APG. The medical mental health APGs are grouped based on a mental health diagnosis and/or CPT-4 procedure. The medical mental health APG is the one not consolidated or packaged, but the mental health incidental procedure APG intermediate groupings can provide valuable information. For example, if the interest is only in psychiatric therapeutic procedures, then the incidental procedure APGs would have that information.

In Table 7 below, the APG frequencies by broad categories are presented, both before and after consolidation. While some procedures are always packaged or consolidated, others are dependent upon the combination of other procedures or services furnished. This is why APGs can't effectively be assigned on individual services, but must be assigned in consideration of all other services provided during an encounter. Additionally, weights must be calculated only on procedures that are exclusive of other procedures or services, or in the case of episode weights such as for pregnancy and delivery, they must be inclusive of all services furnished.

Table 7

Frequency of Ambulatory Patient Group Categories Before and After Consolidation and Ancillary Packaging

	PRIOR TO CONSOLIDATION & ANCILLARY PACKAGING		AFTER CONSOLIDATION & ANCILLARY PACKAGING	
APG CATEGORY	FREQUENCY	PERCENT	FREQUENCY	PERCENT
Professional Svcs	202,589	35.1	0	0.0
Medical APGs	108,975	18.9	108,975	47.8
Laboratory	81,858	14.2	32,883	14.4
Significant Procedures	56,989	9.9	41,451	18.2
Mental Health Services	41,888	7.3	0	0.0
Radiology	36,737	6.4	19,695	8.6
Ancillary Tests	19,056	3.3	1,604	0.7
Admitted or Died	14,090	2.4	14,090	6.2
Pathology	7,362	1.3	2,485	1.1
Well Care & Admin	6,945	1.2	6,945	3.0
Therapeutic Radiology	939	0.2	0	0.0

One problem in consolidation or packaging of procedure APGs as flagged by the APG software is that there is no indication as to which other procedure a procedure should be packaged with. According to the Definitions Manual (Averill et al., 1991), there is a significant procedure hierarchy, and if more than one significant procedure appears on the encounter for the same condition, then the one requiring the most resources would be the unconsolidated, with the other significant procedures flagged for consolidation. With the assumption that generally there would only be one unconsolidated significant procedure on an encounter,

we have combined any payments for consolidated or packaged procedures with the payments for the first non-flagged significant procedure found in the encounter.

For the medical APGs, the payments for all procedures flagged for consolidation are combined for the medical APG payment. Any procedures for tests or ancillary services that were not flagged for consolidation are counted separately, with their payments separate from the medical APG.

There were a total of 130,010 encounters assigned a medical APG. This represented 73.5 percent of the sample file. Each encounter averaged 1.7 procedures. Table 8 shows the categories of procedures found on the medical APG encounters, together with the number consolidated or not consolidated.

Table 8

Medical APG Consolidation

CATEGORY & CONSOLIDATION	NUMBER PROCEDURES	AMOUNT ALLOWED
CONSOLIDATED PROCEDURES:		
Medical	156,863	$7,036,467
Radiology	12,392	795,905
Pathology	35,999	746,426
Total Consolidated	205,254	$8,578,798
NON-CONSOLIDATED PROCEDURES:		
Medical	12,290	$1,384,048
Radiology	1,875	255,591
Pathology and laboratory	4,696	149,142
Total Not Consolidated	18,861	$1,788,781
TOTAL MEDICAL APG Procedures	224,115	$10,367,579

All physician visits were included in the medical procedures category. Because they are all flagged for consolidation, they comprise the largest category for consolidation. Although most of the procedures are flagged for consolidation, if you consider that this sample file is only two percent of the FY 1989 file, there would be approximately $90 million paid for the procedures not consolidated in addition to approximately $429 million for the medical APGs. Again, these are only the medical APG encounters.

Statistical Behavior of APGs

Statistical testing of the data was performed for the complete sample data set, as well as the medical APGs and the procedural APGs separately. The consolidation and ancillary packaging flags returned by the APG grouper software were applied for some tests. The medical and significant procedure APGs were mutually exclusive. However, either could also have incidental or ancillary APGs assigned to the encounter.

For the medical APGs, the amounts allowed for each procedure were summed to compute a price per APG, with the exception of amounts allowed for ancillary or incidental APGs not having a flag indicating consolidation or ancillary packaging. This was also true for the ancillary procedures with the procedural APGs; the amounts allowed for APGs flagged for consolidation or ancillary packaging were added to the significant procedure APG amount allowed in the encounter. The amount allowed for all unconsolidated or unpackaged ancillary or incidental procedures was

assigned to that APG and used with the medical and significant procedure groupings for statistical testing.

Coefficients of variation were computed for both the procedural and the medical APGs after the consolidation process. The purpose of computing coefficients of variation was to assess the homogeneity of the APG groups. Coefficients were first computed using every unconsolidated APG. However, upon examination it was evident there were aberrant observations causing unacceptable variability within the groups. These data were then trimmed to three standard deviations from the mean, which will in a normal distribution include about 99.7% of the data. New coefficients of variation were then computed, and this resulted in a marked improvement in homogeneity of the groups. These coefficients are presented in Appendix K. Table 9 lists by APGs the smallest and largest coefficients of variation found in the trimmed data.

A General Linear Model (GLM) was used to determine how well the APG system did in explaining amount of variability in the dollar "amount allowed". The GLM procedure used is a packaged procedure in the SAS computing library.

The R-squares computed separately for the procedure APGs were very high, particularly after trimming the data to three standard deviations. Variation accounted for within the medical APGs was not as high, but still, considering the small number of groups, would be a more preferable tool for analysis than using existing methodologies such as coded diagnoses or procedures. Table 10 shows statistics after the various testing strategies.

Table 9

APG Coefficients of Variation, Largest and Smallest

APG	APG TITLE	COUNT	MEAN	CV
LARGEST CVS:				
461	INTRODUCTION OF NEEDLE AND CATHETER	678	15.25	2.41
605	MALIGNANCY EXCPT HEMATO,PROSTATIC,LUNG,SKN	1428	104.63	1.74
751	CATARACTS	248	80.97	1.66
417	TISSUE TYPING	99	20.52	1.61
771	HEARING LOSS	140	60.39	1.44
604	SKIN MALIGNANCY	127	72.41	1.41
887	RENAL FAILURE	95	135.15	1.41
212	SIMPLE PENILE PROCEDURES	407	121.92	1.39
736	TIA, CVA AND OTHER CEREBROVASCULAR EVENT	268	116.39	1.35
602	PROSTATIC MALIGNANCY	88	88.54	1.34
796	CONGESTIVE HEART FAILURE & ISCHEMIC HEART	989	90.66	1.29
738	CENTRAL NERVOUS SYSTEM DISEASES EXCEPT T	2082	94.51	1.27
SMALLEST CVS:				
667	COMPREHENSV THERAPY FOR DRUG ABUSE WO MENT	241	75.80	0.30
359	MYELOGRAPHY	29	250.21	0.29
290	COMPLEX LASER EYE PROCEDURES	32	983.30	0.28
165	THERAPEUTIC LOWER GI ENDOSCOPY	71	1008.25	0.26
439	LITHIUM LEVEL MONITORING	32	17.15	0.25
657	COMPREHENSV PSYCHIATRIC EVALUATN,TRMT,0-17	4253	79.87	0.25
289	SIMPLE LASER EYE PROCEDURES	43	810.53	0.24
669	FAMILY THERAPY FOR DRUG ABUSE	20	63.28	0.24
656	COMPREHENSV PSYCHIATRIC EVALUATN,TRMT,>17	7839	80.14	0.22
84	COMPLEX ENDOSCOPY OF THE LOWER AIRWAY	15	463.41	0.19
664	COMPREHENSV THERAPY,DRUG ABUSE W MENTAL ILL	31	75.79	0.09

Analysis of the variation in CHAMPUS professional services data classified by APGs confirmed that the APG methodology is a more superior grouping method than aggregation by traditional groupings such as ICD-9-CM chapters, three-digit ICD-9-CM code rubrics, CPT-4 procedure codes, or other grouping techniques previously used for this type of analysis.

Table 10

Encounter Sample File Statistics

	R-square	Coefficient of Variation
Untrimmed data, no consolidation or ancillary packaging		
Procedure and Ancillary APGs	.43	1.91
Medical APGs	.04	1.96
Trimmed data, no consolidation or ancillary packaging		
Procedure and Ancillary APGs	.59	1.53
Medical APGs	.15	0.87
Trimmed data, eliminating APGs flagged for consolidation, ancillary packaging:		
Procedure and Ancillary APGs	.66	1.42
Medical APGs	.17	1.14
All APGs	.62	1.34

The APGs were designed to provide a flexible method for developing ambulatory resourcing strategy. The grouping software not only provides the groupings or classification system, but also provides the algorithms for bundling or packaging of services. The system has been designed, however, so that these algorithms can be changed or implemented as policies dictate, and are completely separate from the classification system. Allowing multiple APG assignments allows the bundling routine to determine which APGs will be used to establish resource allocation.

There is a continuum of bundling options that could be employed. An episode of illness approach to bundling with capitation could very well be the next step in the evolution of the bundling of ambulatory services. The degree of bundling that is

acceptable is a policy decision, and again, should be unique to military missions and considerations.

During the formation of APGs, charge data was used to reflect the relative needs of patients. The number of visits and ancillary services consumed by patients idealistically depends on their needs. However, ambulatory charge data are highly influenced by RVU scales. Thus, ambulatory charges for a procedure do not necessarily reflect the actual needs or complexity of an individual patient but are based on the established RVU for the procedure. APG developers recognized this, and in forming the APGs, realized it was necessary for the clinical team to make judgments on whether observed charge differences across different procedures reflected real differences in the resources required to perform the procedure or the bias of the established RVU scales. Although statistical results from charge data often simply reflect the established RVU scales, this influence is diminished to a degree in the CHAMPUS professional services ambulatory data because the APG developers tried to work around this situation. Any interpretation of statistical findings, however, must take this into consideration.

Resource-Based Relative Value System (RBRVS)

In Phase I of the RBRVS research, the Harvard team identified the physicians work relative value unit (RVU) as the heart of the RBRVS. A physician's work consists of pre-, intra-, and post-service work. Vignettes, or descriptions, of physicians services for 372 services covering 18 specialties were

constructed. A national random sample of approximately 3,300 physicians (approximately 185 in each specialty) were surveyed on intra-service work resource inputs. Intra-service work was defined in terms of the physician's work, time, and intensity. Intensity consists of technical skill and physical effort, mental effort, and stress. A technique called Magnitude Estimation was used for the survey; each dimension was rated in reference to a known service using a ratio scale. The data from the survey was then used to calculate both pre- and post-service work to yield a total work value for each surveyed service.

Using a panel of physicians in each specialty, the specialty scales were linked by identifying either same or similar services between specialties. This reduced 18 specialties to one common scale without changing the relationships within the specialties.

The 372 unique physician services representing 200 CPT-4 codes were investigated through the survey process. The Harvard team used the survey results to extrapolate the total number of services to 1400 by identifying small families of sevices, with the assumption that charges within these families bore a reasonable relationship to the relative work value within such families. A benchmark service that had been surveyed was then selected from each family of services. Ratios were calculated of charges between this service and non-surveyed services in the same family, and the work values of the surveyed services was multiplied by this ratio to get the extrapolated work value for the non-surveyed services. These sevices represent 1,200 unique CPT-4

codes. By adding modifiers, the total number of CPT codes covered was increased to 1,400 (HCFA, 1991, June 5).

Findings from Phase I indicated that evaluation and management services are compensated at a lower rate relative to resource costs than are invasive, imaging, and laboratory services. In general, it appeared that evaluation and management services are compensated two to three times less than the rate of invasive services, whether performed by surgeons, internists, or family practitioners. The Harvard team further investigated these issues in Phase II of their study.

The second phase of the RBRVS research was undertaken to address the shortcomings identified in Phase I and to expand the scope of the study to include 15 additional medical and surgical specialties plus the resurveying of seven Phase I specialties. A major team emphasis in Phase II was dealing specifically with the refinement of processes used in cross specialty linking, extrapolation from surveyed to non-surveyed services, and pre- and post-survey work estimates. While incorporating the refinements, the Harvard team developed an additional 753 vignettes covering the 22 specialties that account for 409 CPT codes. The Harvard team, in total, surveyed 33 specialties.

RBRVS researchers reported that one of the most difficult parts of the study was to place the different specialties on a common scale, i.e., cross specialty alignment. In Phase II, the 22 specialties were linked into one common scale by three distinct specialty panels. The links were weighted by the variance to refine the quantitative method of connecting the links. This

process gave greater weight to links with the least variance. The Harvard team extrapolated the work values of 409 unique services to more than 2,700 by the end of Phase II.

One of the issues that was reevaluated was the measurement of pre- and post-service work. In the first phase, pre- and post-service work was found to represent almost fifty percent of total work of invasive services and about thirty-three percent of evaluation and management services. One criticism of this finding was that there was insufficient data for these findings, too many assumptions made, and no validation of findings. In the second phase the Harvard team obtained a number of direct estimates of pre- and post-service work. Of 46 ambulatory invasive services, over two-thirds were directly surveyed. More than 75 in-hospital surgical services were directly surveyed and estimates obtained on pre- and post-service work. In additon, the Harvard team supplemented their survey data by obtaining estimates of pre- and post-service work from the technical consulting groups and expert panels from general surgery and opthalmology.

By the end of Phase II, the team had developed 5,752 relative values representing over 4,150 CPT-4 codes. While this represents 85 percent of the Medicare dollars (Hsaio et al., 1990), it represents a smaller percentage of CHAMPUS dollars, since the high-volume procedures in the Medicare and CHAMPUS data sets are quite different. At any rate, the number of values assigned was further expanded in Phase III, and the Phase II and Phase III values are those included in the Final Rule as published in the Federal Register for Medicare payment of

physician services beginning January 1, 1992 (HCFA, 1991, November 25).

Under Section 6102 of Public Law 101-239, the Omnibus Budget Reconciliation Act of 1989 amended Title XVIII of the Social Security Act (the Act) by adding section 1848. One major element of the new section is the replacement of the reasonable charge payment mechanism with a fee schedule for physicians'services. The Medicare fee schedule being implemented on January 1, 1992 by HCFA will "apply to physician services; services of limited licensed practitioners, diagnostic test other than clinical diagnostic laboratory tests; diagnostic and therapeutic radiology services; and physical and occupational therapy" (HCFA, Nov 25, 1991). Even though they are not specifically covered by the fee schedule, non-physician practitioners' payments will be based on fee schedule amounts. For example, physician assistants will be limited to 65 percent of the fee schedule amount for assistant-at-surgery charges, 75 percent of the fee schedule amount for services furnished in a hospital, and 85 percent of the fee schedule amount for all other services. Since Section 1848(c)(6) of the Act prohibits the Secretary from imposing different RVUs or a different conversion factor (CF) for physicians' service based solely on the specialty, optometrists, dentists, oral and maxillofacial surgeons, podiatrists, and chiropractors will apply the fee schedule the same way physicians do but as limited licensed practitioners. A site of service differential of 50 percent of the practice RVU will apply to some office based services when the service is provided in a hospital

outpatient department. The specific services are listed in Addendum F of the November 25, 1991 Federal Register (Final Rule). Supplies and service incident to a physician's service are being incorporated into the practice expense RVU.

Addendum G of the Final Rule lists the procedures for which an additional amount for supplies may be payable if performed in a physician's office. Durable medical equipment (DME) will continue to be reimbursed under the prevailing charge methodology as determined by the local carrier. Since Public Law 101-508 does not allow separate payment for EKG interpretations by physicians, HCFA has increased the visit RVUs to include an allowance for the EKG interpretations.

Section 1848(b)(1) of the Act requires the fee schedule to be computed as the product of three factors: (1) A relative value for the services, (2) the Geographic Adjustment Factor (GAF), and (3) a nationally uniform conversion factor. The relative value for services is comprised of three components: physician work, practice expenses (overhead costs such as rent, staff salaries, equipment, and supplies, and professional liability insurance or malpractice costs). The Final Rule states, "Section 1848(c)(1) of the Act defines the components of the RVU for a physician service. The physician work RVU must reflect the physician resources required to furnish the service, including time and intensity of effort. Under the formula specified at section 1848(c)(2)(C), the practice expense and malpractice RVUs are based on historical data for practice expense as a fraction of total physician revenue, weighted by specialty, applied to

estimated 1991 average allowed charges under the customary, prevailing, and reasonable charge methodology. Separate geographic practice cost indices (GPCI) have been developed for each fee schedule component to accommodate the statutory requirement for the GAF.

The component RVU is multiplied by the appropriate GPCI. In effect, each component is separately adjusted by the GPCI specific to that component. The three adjusted component RVUs are then summed to a total RVU for that service. This total RVU is converted to a dollar payment by applying the uniform national conversion factor. The 1992 uniform national CF is 31.001. The sources of each of the elements of the payment formula are covered in detail in the November 25, 1991 Federal Register.

RBRVS and CHAMPUS Professional Services Data

CHAMPUS policies require the use of special purpose procedure codes for the following categories:

1. Computed Tomography Scanning Procedures
2. Well-Baby Care Procedures
3. Outpatient Hospital, Ambulatory Surgical Center, Birthing Center, and Hospital-Outpatient Birthing Room Claims
4. Durable Medical Equipment and Medical Supplies
5. Osteopathic Manipulative Therapy
6. Special Procedural Codes
7. Special Statistical Tracking Codes
8. Ambulance Service Procedures
9. CPT-4 Code Exceptions (Anesthesia)

10. Mental Health Procedures

11. Eye Examination - Basic Program

12. Special Program for the Handicapped

Codes for these categories are listed in OCHAMPUS Operations Manual, Appendix J.

A total of 130 CHAMPUS-unique procedure codes were translated from the twelve categories listed above. These CHAMPUS-unique codes were first crosswalked to the CPT-4 code. Additionally, for office visit codes, a translation was also made to the new 1992 codes presented with the physician fee schedule. The visit codes were translated twice for two reasons. First, the CPT-4 codes used for visits in FY 1989 are those required for APG analysis. Second, to insure an accurate audit trail exists for code translations, the CPT-4 codes would need to appear as the old codes listed in the translation table presented on pages 59580-59581 in the Federal Register (HCFA, 1991, November 25).

One of the problem areas in the data was the inability to determine sites of service in many instances. No modifiers were included in the data files, which is contrary to most claims data bases. It would have been very helpful to have been able to separate facility and professional services based on modifiers.

Some of the procedures that were crosswalked have large ranges associated with their amounts allowed. Sixty-two, or almost fifty-two percent of the CHAMPUS-unique codes were crosswalked to CPT-4 procedure code 99070, Supplies and Materials. This procedure represents 6.45 percent (20,892 procedures) of the encounter sample data file. Under the new fee schedule, HCPCS's

procedure code 99070 has a total RBRVS value of 0.00, since the supplies associated with office based procedures will now be included in the practice expense relative value units. In the CHAMPUS data files, after translation of the codes, the 99070 procedure demonstrated high variability when looking at amounts allowed for the service.

Another area requiring consideration is the crosswalking of Anesthesia procedure codes. As discussed previously, CHAMPUS required all anesthesia service claims to be coded under the surgical procedure rather than the CPT-4 anesthesia code. CHAMPUS's anesthesia claims are identified by the provider specialty code rather than the CPT-4 procedure code. The study team is presently addressing different methods that could be used for crosswalking those CPT-4 surgical procedure codes with anesthesia major specialty codes to CPT-4 anesthesia procedure codes. However, because of time constraints and since the number of anesthesia claims are small, this may not be feasible.

HCFA has used the revised CPT-4 Evaluation and Management codes for 1992 in their physician fee schedule. The crosswalk we discussed previously (Appendix G) generally follows the conventions reported in the tables listed under the caption, "Crosswalk for CPT Evaluation and Management Codes New in 1992" in the November 25th issue of the Federal Register (1991). There were minor issues that arose due to HCFA's crosswalk methodology. First, we crosswalked procedure codes 99062 - 99065 (Emergency care facility services, non-hospital based physician) to procedure code 99283 (Emergency department visit for evaluation and

management of a patient), whereas HCFA called for deletion of those codes for physician payment. The data in those codes constituted less than one percent of the Encounter procedures and services.

Additionally, HCFA crosswalked codes to estimate the volume of new visit codes for the conversion factor calculation and to develop practice expense and malpractice expense RVUs for the new evaluation and management codes. This process required assigning a percentage of an old code to a new code for use in the weighted average historical payments methodology for determining practice and malpractice expense RVUs. For example, the old procedure code 90360 (Skilled nursing facility, subsequent care) was reassigned to three new procedure codes by percentages. They are codes 99301 (25 percent), 99312 (50 percent), and 99313 (25 percent). At this time, this methodology has not been adopted for this study. Rather, translation was made from old code to either the new code with the highest percentage, or the best fit based on code description when the percentages were equal.

Generalized policies and rules listed in the CHAMPUS Operational and Policy Manuals were used in assigning the RBRVS units to the CHAMPUS data. One very significant reimbursement policy states that the reimbursable costs for pathology or radiology services furnished to an inpatient are paid as professional components only, since the technical component is reimbursed under the DRG payment (CHAMPUS Policy Manual Volume II, p. 6.1.D.3). Therefore, given an encounter record with an inpatient status code and either a pathology or radiology procedure code,

the RBRVS professional component was applied (if that procedure had a professional component in the fee schedule).

Under the fee schedule, HCFA has determined that there are 59 pathology physician services. The remaining pathology services are considered clinical diagnostic laboratory services that are not covered under the physician fee schedule (HCFA, 1991, November 25, p. 59010). Therefore, given an encounter record with an outpatient status code and a singular occurrence of a pathology or radiology code, the RBRVS code with the total work unit was assigned for that specific procedure.

There were some encounter records with duplicate procedure codes (approximately nine percent). They were found in both the inpatient and outpatient professional services encounter records. These will be investigated further to determine whether they represent bilateral procedures or, in the case of mental health, codes to account for additional increments of time for consultations or therapy visits.

Table 3 in Addendum J of the Operations Manual lists procedure codes used for facility based services. When these codes appeared on an encounter record, all other services listed on this encounter are presumed to be facility based. Analyses completed up to this point have made no attempt to separate facility-based and office-based services, and both APGs and RBRVS values have been assigned for all procedures. However, it is planned to make this separation, and APGs will be evaluated using encounter records containing facility-based procedure codes. The

RBRVS will be evaluated using only the office based professional services.

Excerpts from the RBRVS are attached as Appendix L, demonstrating how modifiers are given with the procedure codes for the technical and professional components. The modifier "26" represents the professional component, and "TC" the technical component. Also included in Appendix L are some of the largest and smallest values for Total RVU. The totals range from a low of 0.10 to a high of 102.64.

RVUs were assigned to 321,659 procedures, or 98.26 percent of the procedures found in the sample file. This assignment accounted for $26.0 million (97 percent of the dollar amounts allowed).

Not all procedure codes contained in the Medicare fee schedule have a RVU greater than zero. Of the 10,158 procedures listed, 3,226 (31.76 percent) contain total RVU values of 0.00. The reasons that zero values were assigned are defined using status codes in the fee schedule. Status of procedure codes denoted bundling of procedures, carrier priced procedures, deleted procedures, those excluded from the physician fee schedule, non-covered services, deleted visit codes, and procedures excluded for statutory reasons.

Status code "A" (active code) comprises 56.3 percent of the services and 74.1 percent of the dollar volume of the assigned CHAMPUS sample file data. Payments for two groups of procedures (status code "T" for Injections, and status code "Z" for electrocardiograms) are dependent upon where or not a payment is made on

the same day for a visit. If payment is made for a visit, the payment for the injection or electrocardiogram is disallowed because it is included in the visit payment. Electrocardiograms (status code "Z") and Injections (status code "T") comprise 1.0 percent and 0.5 percent of the services and 1.5 percent and 0.4 percent of the dollar volume respectively. The remaining 41.3 percent for services and 24.9 percent for dollar volume is accounted for by various bundling, exclusions, and carrier pricing rules in the Medicare Program implementation of the fee schedule.

Carrier priced (status code "C"), excluded (status code "E"), and statutory exclusions (status code "X") procedures account for 24.5 percent of the data file. The Medicare fee schedule contains 2,454 procedures listed under these status codes. HCFA requires payments for procedures listed under the three status codes to be determined either individually by the carrier or under the reasonable charge methodology.

Another status code of particular interest is status code "B" for bundled services. In the sample file, procedures identified with a bundled status account for 15.2 percent of the services and 9.3 percent of the dollar volume. This dollar volume equates to $2.4 million. HCFA states that the payment for these types of service (listed at Appendix N) is included with the service for which it is incident. As stated in the Federal Register, (HCFA, 1991, Nov 25, p.59631),

> An example is a telephone call from a hospital nurse regarding care of a patient. This service is not separately payable because it is included in the payment for other services such as hospital visits.

This particular approach is controversial, especially since the work RVU was developed using time as one of the bases of measurement. The procedures listed in Appendix N require the physician's time as the major component of resources required in performance of the procedure.

CONCLUSIONS

CHAMPUS professional services data, although collected for fiscal adjudication of claims, can be very useful for research purposes if used correctly. The data files are massive, and as such lend themselves very well to classification systems such as Ambulatory Patient Groups.

Encounter files can be developed from the CHAMPUS claims data. Based on beginning date of care, claims can be separated or combined, as required, to portray the array of services provided to a single patient on a given day. Use of encounter files is necessary in order to correctly assign APGs, since medical APGs are assigned not only based on a particular service, but also the presence(or absence) of other services during the visit. The bundling routines that are part of the APG grouping software could not be used on systems where services are separated into individual records. Additionally, to correctly develop weights for the APGs, global billings that cover more than one service will have to be taken into account. This is only possible when the services are aggregated to an encounter.

Certain preprocessing of the CHAMPUS data must take place prior to classification to Ambulatory Patient Groups or assignment of Resource Based Relative Values. Any four-digit diagnosis code that has a valid five-digit expansion category must be mapped prior to application of the grouping software. Additionally, CHAMPUS-unique procedures must also be translated to CPT-4

codes prior to any grouping using currently available classification system software.

Processing of the huge volume of CHAMPUS professional services claims reinforced the notion that data elements collected for ambulatory care data systems should be kept to a minimum. Although the information industry has made tremendous advances in computing technology, there still must be a recognition that a data collection system cannot be all things to all people.

Ambulatory Patient Groups can be effectively assigned to CHAMPUS claims data. More than ninty-eight percent of the Encounter sample file received a valid and appropriate APG assignment. The software is easy to use, and on the trimmed file, APG groupings account for 62 percent of the variation in dollar amounts allowed for the service.

Resource-based relative values can also be effectively assigned to CPT-4 procedures for services in the Encounter file. Almost one hundred percent of the CPT-4 procedures in the CHAMPUS sample file were assigned a Resource Based Relative Value from the physicians' fee schedule. Assessment of the fee schedule in terms of cost shifts between specialties will be addressed in the next project report. Additionally, the global payment methodology afforded by the RBRVS versus payment by unbundled procedures will be evaluated.

Bundling issues enter into both classification of data to Ambulatory Patient Groups and assignment of Resource Based Relative Values. Decisions would have to be made regarding accepting the bundling as recommended through the APG grouper software,

accepting no bundling of services, or somewhere on a continuium between the two extremes. RBRVS values are 0.0 for the procedures or services for which bundling is being instituted in payment for Medicare physicians' services. Weights for those services would have to be developed if particular bundlings were found to be unacceptable.

CHAMPUS data complements rather than mirrors the direct care system. Although some of the same types of cases are seen in both systems, preventive care was not found to be as predominant in the CHAMPUS data as it is in the direct care system. However, CHAMPUS covers the whole array of disorders and treatments, as evidenced by assignments to all APG categories. Because of the lack of collection of ambulatory data in the direct care system, information from this study can be helpful in planning and policy decisions for the direct care system, so long as differences are recognized.

Ambulatory Patient Groups can be used very effectively for resource allocation or budgeting, as well as case-mix comparisons between providers, departments, facilities, or regions. Weights must be developed, however, that will reflect the resources required to provide the care under CHAMPUS. Additionally, Resource Based Relative Values are already being used in the Medicare system, and likely will soon be used in CHAMPUS, to pay for physicians' services. The combination of Ambulatory Patient Groups, for payment of facility payments, and Resource Based Relative Values, for payment of physicians' services, will provide better tools for analysis and resource allocation.

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APPENDIX A

AMBULATORY PATIENT GROUPS

APPENDIX A

Ambulatory Patient Groups

SIGNIFICANT PROCEDURE APGS:

APG	TITLE
	SKIN, SUBCUTANEOUS TISSUE AND MUSCLE
1	PHOTOCHEMOTHERAPY
2	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION
3	SIMPLE INCISION AND DRAINAGE
4	COMPLEX INCISION AND DRAINAGE
5	DEBRIDEMENT OF NAILS
6	SIMPLE DEBRIDEMENT AND DESTRUCTION
7	SIMPLE EXCISION AND BIOPSY
8	COMPLEX EXCISION, BIOPSY AND DEBRIDEMENT
9	LIPECTOMY AND EXCISION WITH RECONSTRUCTION
10	SIMPLE SKIN REPAIR
11	COMPLEX SKIN REPAIR
12	SKIN AND INTEGUMENT GRAFT, TRANSFER AND REARRANGEMENT
	BREAST
27	SIMPLE INCISION AND EXCISION OF BREAST
28	BREAST RECONSTRUCTION AND MASTECTOMY
	BONE, JOINT AND TENDON
53	OCCUPATIONAL THERAPY
54	PHYSICAL THERAPY
55	DIAGNOSTIC ARTHROSCOPY
56	THERAPEUTIC ARTHROSCOPY
57	REPLACEMENT OF CAST
58	SPLINT, STRAPPING AND CAST REMOVAL
59	TREATMENT OF CLOSED FRACTURE & DISLOCATION OF FINGER, TOE & RIB
60	TREATMENT OF CLOSED FRACTURE & DISLOCATION EXCEPT FINGER, TOE & RIB
62	TREATMENT OF OPEN FRACTURE AND DISLOCATION EXCEPT FACE
63	JOINT MANIPULATION UNDER ANESTHESIA
64	SIMPLE MAXILLOFACIAL PROCEDURES
65	COMPLEX MAXILLOFACIAL PROCEDURES
66	INCISION OF BONE, JOINT AND TENDON
67	BUNION PROCEDURES
68	EXCISION OF BONE, JOINT AND TENDON OF TH
69	EXCISION OF BONE, JOINT & TENDON EXCEPT
70	ARTHROPLASTY
71	HAND AND FOOT TENOTOMY

APG	TITLE
	BONE, JOINT AND TENDON (CONT)
72	SIMPLE HAND AND FOOT REPAIR EXCEPT TENOT
73	COMPLEX HAND AND FOOT REPAIR
74	REPAIR,EXCEPT ARTHROTOMY,OF BONE,JOINT,TENDON EXCEPT OF HAND & FOOT
75	ARTHROTOMY EXCEPT OF HAND AND FOOT
76	ARTHROCENTESIS AND LIGAMENT OR TENDON INJECTION
77	SPEECH THERAPY
	RESPIRATORY, MOUTH, NOSE AND THROAT
79	PULMONARY TEST AND THERAPY EXCEPT SPIROMETRY
80	NEEDLE AND CATHETER BIOPSY, ASPIRATION,LAVAGE & INTUBATION
81	SIMPLE ENDOSCOPY OF THE UPPER AIRWAY
82	COMPLEX ENDOSCOPY OF THE UPPER AIRWAY
83	SIMPLE ENDOSCOPY OF THE LOWER AIRWAY
84	COMPLEX ENDOSCOPY OF THE LOWER AIRWAY
85	NASAL CAUTERIZATION AND PACKING
86	SIMPLE LIP, MOUTH AND SALIVARY GLAND PROCEDURES
87	COMPLEX LIP, MOUTH AND SALIVARY GLAND PROCEDURES
88	MISCELLANEOUS SINUS, TRACHEAL AND LUNG PROCEDURES
	CARDIOVASCULAR
105	EXERCISE TOLERANCE TESTS
106	ECHOCARDIOGRAPHY
107	PHONOCARDIOGRAM
108	CARDIAC ELECTROPHYSIOLOGIC TESTS
109	VASCULAR CANNULATION WITH NEEDLE AND CATHETER
110	DIAGNOSTIC CARDIAC CATHETERIZATION
111	ANGIOPLASTY AND TRANSCATHETER PROCEDURES
112	PACEMAKER INSERTION AND REPLACEMENT
113	REMOVAL AND REVISION OF PACEMAKER AND VASCULAR DEVICE
114	MINOR VASCULAR REPAIR AND FISTULA CONSTRUCTION
115	SECONDARY VARICOSE VEINS AND VASCULAR INJECTION
116	VASCULAR LIGATION
117	CARDIOPULMONARY RESUSCITATION AND INTUBATION
	HEMATOLOGIC, LYMPHATIC AND ENDOCRINE
131	CHEMOTHERAPY BY INFUSION
132	CHEMOTHERAPY EXCEPT BY INFUSION
133	TRANSFUSION AND PHLEBOTOMY
134	BLOOD AND BLOOD PRODUCT EXCHANGE
135	DEEP LYMPH STRUCTURE AND THYROID PROCEDURES
136	ALLERGY TESTS AND IMMUNOTHERAPY

APG	TITLE
	DIGESTIVE
157	ALIMENTARY TESTS AND SIMPLE TUBE PLACEMENT
158	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY
159	PERCUTANEOUS AND OTHER SIMPLE GASTROINTESTINAL BIOPSY
160	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROCTOSIGMOIDOSCOPY
161	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIOPSY
162	DIAGNOSTIC UPPER GASTROINTESTINAL ENDOSCOPY
163	THERAPEUTIC UPPER GASTROINTESTINAL ENDOSCOPY
164	DIAGNOSTIC LOWER GASTROINTESTINAL ENDOSCOPY
165	THERAPEUTIC LOWER GASTROINTESTINAL ENDOSCOPY
166	ERCP & OTHER MISCELLANEOUS GASTROINTESTINAL ENDOSCOPY PROCEDURES
167	TONSIL AND ADENOID PROCEDURES
168	HERNIA AND HYDROCELE PROCEDURES
169	SIMPLE HEMORRHOID PROCEDURES
170	SIMPLE ANAL AND RECTAL PROCEDURES EXCEPT HEMORRHOID PROCS
171	COMPLEX ANAL AND RECTAL PROCEDURES
172	PERITONEAL PROCEDURES AND CHANGE OF INTRA-ABDOMINAL TUBE
173	MISCELLANEOUS DIGESTIVE PROCEDURES
	URINARY
183	SIMPLE URINARY STUDIES AND PROCEDURES
184	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRI
185	URINARY CATHETERIZATION AND DILATATION
186	HEMODIALYSIS
187	PERITONEAL DIALYSIS
188	SIMPLE CYSTOURETHROSCOPY
189	COMPLEX CYSTOURETHROSCOPY AND LITHOLAPAX
190	PERCUTANEOUS RENAL ENDOSCOPY, CATHETERIZATION & URETERAL ENDOSCOPY
191	CYSTOTOMY
192	SIMPLE URETHRAL PROCEDURES
193	COMPLEX URETHRAL PROCEDURES
	MALE REPRODUCTIVE
209	TESTICULAR AND EPIDIDYMAL PROCEDURES
210	INSERTION OF PENILE PROSTHESIS
211	COMPLEX PENILE PROCEDURES
212	SIMPLE PENILE PROCEDURES
213	PROSTATE NEEDLE AND PUNCH BIOPSY
214	TRANSURETHRAL RESECTION OF PROSTATE & OTHER PROSTATE PROCEDURES

APG	TITLE
	FEMALE REPRODUCTIVE
235	ARTIFICIAL FERTILIZATION
236	PROCEDURES FOR PREGNANCY AND NEONATAL CARE
237	TREATMENT OF SPONTANEOUS ABORTION
238	THERAPEUTIC ABORTION
239	VAGINAL DELIVERY
240	FEMALE GENITAL ENDOSCOPY
241	COLPOSCOPY
242	MISCELLANEOUS FEMALE REPRODUCTIVE PROCEDURES
243	DILATION AND CURETTAGE
244	FEMALE GENITAL EXCISION AND REPAIR
	NERVOUS
261	ELECTROENCEPHALOGRAM
262	ELECTROCONVULSIVE THERAPY
263	NERVE AND MUSCLE TESTS
264	INJECTION OF SUBSTANCE INTO SPINAL CORD
265	SUBDURAL AND SUBARACHNOID TAP
266	NERVE INJECTION AND STIMULATION
267	REVISION AND REMOVAL OF NEUROLOGICAL DEVICE
268	NEUROSTIMULATOR AND VENTRICULAR SHUNT IMPLANTATION
269	CARPAL TUNNEL RELEASE
270	NERVE REPAIR AND DESTRUCTION
271	COMPLEX NERVE REPAIR
272	SPINAL TAP
	EYE
287	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDURES
288	FITTING OF CONTACT LENSES
289	SIMPLE LASER EYE PROCEDURES
290	COMPLEX LASER EYE PROCEDURES
291	CATARACT PROCEDURES
292	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES FOR GLAUCOMA
293	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES FOR GLAUCOMA
294	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES EXCEPT FOR CLAUCOMA
295	MODERATE ANTERIOR SEGMENT EYE PROCEDURES
296	COMPLEX ANTERIOR SEGMENT EYE PROCS EXCEPT FOR GLAUCOMA
297	SIMPLE POSTERIOR SEGMENT EYE PROCEDURES
298	COMPLEX POSTERIOR SEGMENT EYE PROCEDURES
299	STRABISMUS AND MUSCLE EYE PROCEDURES
300	SIMPLE REPAIR AND PLASTIC PROCEDURES OF EYE
301	COMPLEX REPAIR AND PLASTIC PROCEDURES OF EYE

APG	TITLE
	EAR
313	OTORHINOLARYNGOLOGIC FUNCTION TESTS
314	MAJOR EXTERNAL EAR PROCEDURES
315	TYMPANOSTOMY AND OTHER SIMPLE MIDDLE EAR PROCEDURES
316	TYMPANOPLASTY AND OTHER COMPLEX MIDDLE EAR PROCEDURES
317	INNER EAR PROCEDURES
318	SIMPLE AUDIOMETRY
319	REMOVAL OF IMPACTED CERUMEN

ANCILLARY TEST AND PROCEDURE APGS:

APG	TITLE
	RADIOLOGY
341	SIMPLE DIAGNOSTIC NUCLEAR MEDICINE
342	COMPLEX DIAGNOSTIC NUCLEAR MEDICINE
343*	THERAPEUTIC NUCLEAR MEDICINE BY INJECTION
344*	RADIATION THERAPY
345	OBSTETRICAL ULTRASOUND
346	DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL
347*	HYPERTHERMIA
348	MAGNETIC RESONANCE IMAGING
349	COMPUTERIZED AXIAL TOMOGRAPHY
350	MAMMOGRAPHY
351	PLAIN FILM
352	FLUOROSCOPY
353	CEREBRAL, PULMONARY, CERVICAL AND SPINAL ANGIOGRAPHY
354	VENOGRAPHY OF EXTREMITY
355	NON-CARDIAC, NON-CEREBRAL VASCULAR RADIOLOGY
356	DIGESTIVE RADIOLOGY
357	UROGRAPHY AND GENITAL RADIOLOGY
358	ARTHROGRAPHY
359	MYELOGRAPHY
360	MISCELLANEOUS RADIOLOGY

(* RADIOLOGICAL APGS 343, 344, AND 347 ARE TREATED AS SIGNIFICANT PROCEDURES.)

	ANESTHESIA
365	ANESTHESIA
	PATHOLOGY
391	SIMPLE PATHOLOGY
392	COMPLEX PATHOLOGY

APG	TITLE
	LABORATORY
417	TISSUE TYPING
418	HUMAN TISSUE CULTURE
419	SIMPLE IMMUNOLOGY TESTS
420	COMPLEX IMMUNOLOGY TESTS
421	SIMPLE MICROBIOLOGY TESTS
422	COMPLEX MICROBIOLOGY TESTS
423	SIMPLE ENDOCRINOLOGY TESTS
424	COMPLEX ENDOCRINOLOGY TESTS
425	BASIC CHEMISTRY TESTS
426	SIMPLE CHEMISTRY TESTS
427	COMPLEX CHEMISTRY TESTS
428	MULTICHANNEL CHEMISTRY TESTS
429	SIMPLE TOXICOLOGY TESTS
430	COMPLEX TOXICOLOGY TESTS
431	URINALYSIS
432	THERAPEUTIC DRUG MONITORING
433	RADIOIMMUNOASSAY TESTS
434	SIMPLE CLOTTING TESTS
435	COMPLEX CLOTTING TESTS
436	SIMPLE HEMATOLOGY TESTS
437	COMPLEX HEMATOLOGY TESTS
439	LITHIUM LEVEL MONITORING
440	BLOOD AND URINE DIPSTICK TESTS
	ANCILLARY TESTS AND PROCEDURES
443	SPIROMETRY AND RESPIRATORY THERAPY
444	INFUSION THERAPY EXCEPT CHEMOTHERAPY
447	CARDIOGRAM
449	SIMPLE IMMUNIZATION
450	MODERATE IMMUNIZATION
451	COMPLEX IMMUNIZATION
452	MINOR GYNECOLOGICAL PROCEDURES
454	MINOR DOPPLER, ECG MONITORING & AMBULATORY BP MONITORING TESTS
455	MINOR OPHTHALMOLOGICAL INJECTION, SCRAPING AND TESTS
456	VESTIBULAR FUNCTION TESTS
457	MINOR URINARY TUBE CHANGE
458	SIMPLE ANOSCOPY
459	BIOFEEDBACK AND HYPNOTHERAPY
460	PROVISION OF VISION AIDS
461	INTRODUCTION OF NEEDLE AND CATHETER
	INCIDENTAL PROCEDURES
469	PROFESSIONAL SERVICE

APG	TITLE
	INCIDENTAL PROCEDURES (CONT)
470	INDIVIDUAL PSYCHOTHERAPY
471	GROUP PSYCHOTHERAPY
472	PSYCHOTROPIC MEDICATION MANAGEMENT
473	COMPREHENSIVE PSYCHIATRIC EVALUATION AND TREATMENT
474	FAMILY PSYCHOTHERAPY
475	RADIOLOGICAL SUPERVISION AND INTERPRETATION ONLY
478	THERAPEUTIC RADIOLOGY PLANNING AND DEVICE CONSTRUCTION
	CHEMOTHERAPY DRUGS
500	CLASS ONE CHEMOTHERAPY DRUGS
501	CLASS TWO CHEMOTHERAPY DRUGS
502	CLASS THREE CHEMOTHERAPY DRUGS
MEDICAL APGS:	
	MALIGNANCY
601	HEMATOLOGICAL MALIGNANCY
602	PROSTATIC MALIGNANCY
603	LUNG MALIGNANCY
604	SKIN MALIGNANCY
605	MALIGNANCIES EXCEPT HEMATOLOGICAL, PROSTATIC, LUNG & SKIN
	POISONING
616	POISONING
	TRAUMA
631	HEAD AND SPINE INJURY
632	BURNS, AND SKIN AND SOFT TISSUE INJURY
633	FRACTURE, DISLOCATION AND SPRAIN
634	OTHER INJURIES
	MENTAL DISEASES
654	INDIVIDUAL SUPPORTIVE TREATMENT FOR SENILITY, DEMENTIA & MENTAL RETARDATION
655	PSYCHOTROPIC MEDICATION MANAGEMENT AND BRIEF PSYCHOTHERAPY
656	COMPREHENSIVE PSYCHIATRIC EVALUATION AND TRMT AGE > 17
657	COMPREHENSIVE PSYCHIATRIC EVALUATION AND TRMT AGE 0-17
658	FAMILY PSYCHOTHERAPY
659	GROUP PSYCHOTHERAPY

APG	TITLE
	ALCOHOL AND DRUG ABUSE
664	COMPREHENSIVE THERAPY FOR DRUG ABUSE WITH MENTAL ILLNESS
667	COMPREHENSIVE THERAPY FOR DRUG ABUSE WO MENTAL ILLNESS
668	MEDICATION MANAGEMENT AND BRIEF PSYCHOTHERAPY FOR DRUG ABUSE
669	FAMILY THERAPY FOR DRUG ABUSE
670	GROUP THERAPY FOR DRUG ABUSE
	NEONATE
676	NEONATE AND CONGENITAL ANOMALY
	PREGNANCY
691	ROUTINE PRENATAL CARE
692	MATERNAL ANTEPARTUM COMPLICATION
693	ROUTINE POSTPARTUM CARE
694	MATERNAL POSTPARTUM COMPLICATION
	INFECTIOUS DISEASE
721	SYSTEMIC INFECTIOUS DISEASE
723	SEXUALLY TRANSMITTED DISEASE IN MALES
724	SEXUALLY TRANSMITTED DISEASE IN FEMALES
	NERVOUS DISEASES
736	TIA, CVA AND OTHER CEREBROVASCULAR EVENT
737	HEADACHE
738	CENTRAL NERVOUS SYSTEM DISEASES EXCEPT TIA,CVA,& HEADACHE
	EYE DISEASES
751	CATARACTS
752	REFRACTION DISORDER
753	CONJUNCTIVITIS AND OTHER SIMPLE EXTERNAL EYE INFLAMMATION
754	EYE DISEASE EXCEPT CATARACT,REFRACTION DISORDER AND CONJUNCTIVITIS
	EAR, NOSE, THROAT AND MOUTH DISEASES
766	DENTAL DISEASE
767	ACUTE INFECTIOUS EAR, NOSE AND THROAT DISEASE AGE > 17
768	ACUTE INFECTIOUS EAR, NOSE AND THROAT DISEASE AGE 0-17
769	ACUTE NONINFECTIOUS EAR, NOSE AND THROAT DISEASE
771	HEARING LOSS
772	OTHER EAR, NOSE, THROAT AND MOUTH DISEASES

APG	TITLE
	RESPIRATORY DISEASES
781	EMPHYSEMA, CHRONIC BRONCHITIS AND ASTHMA AGE > 17
782	EMPHYSEMA, CHRONIC BRONCHITIS AND ASTHMA AGE 0-17
783	PNEUMONIA
784	RESPIRATORY DISEASE EXCEPT EMPHYSEMA,CHRONIC BRONCHITIS & ASTHMA
	CARDIOVASCULAR DISEASES
796	CONGESTIVE HEART FAILURE AND ISCHEMIC HEART DISEASE
797	HYPERTENSION
800	CARDIOVASCULAR DISEASE EXCEPT CHF,ISCHEMIC HEART DISEASE & HYPERTENSION
	DIGESTIVE DISEASES
811	NONINFECTIOUS GASTROENTERITIS
812	ULCERS, GASTRITIS AND ESOPHAGITIS
813	FUNCTIONAL GASTROINTESTINAL DISEASE & IRRITABLE BOWEL SYND
814	HEPATOBILIARY DISEASE
816	HEMORRHOIDS AND OTHER ANAL-RECTAL DISEASES
817	OTHER GASTROINTESTINAL DISEASES
	MAJOR SIGNS, SYMPTOMS AND FINDINGS
827	MAJOR SIGNS, SYMPTOMS AND FINDINGS
	MUSCULOSKELETAL DISEASES
841	BACK DISORDERS
842	MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
	SKIN AND BREAST DISEASES
856	DISEASE OF NAILS
857	CHRONIC SKIN ULCER
858	CELLULITIS, IMPETIGO AND LYMPHANGITIS
859	BREAST DISEASE
860	OTHER SKIN DISEASES
	ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES
871	DIABETES
872	OBESITY
873	ENDOCRINE,NUTRITIONAL & METABOLIC DISEASE EXCEPT DIABETES AND OBESITY

APG	TITLE
	KIDNEY AND URINARY TRACT DISEASES
886	URINARY TRACT INFECTION
887	RENAL FAILURE
888	URINARY DISEASE EXCEPT URINARY TRACT INFECTION & RENAL FAILURE
	MALE REPRODUCTIVE DISEASES
901	BENIGN PROSTATIC HYPERTROPHY
902	MALE REPRODUCTIVE DISEASES EXCEPT BENIGN PROSTATIC HYPERTROPHY
	FEMALE REPRODUCTIVE DISEASES
916	FEMALE GYNECOLOGIC DISEASE
	IMMUNOLOGIC AND HEMATOLOGIC DISEASES
932	AIDS RELATED COMPLEX & HIV INFECTION WITH COMPLICATIONS
933	OTHER IMMUNOLOGIC AND HEMATOLOGIC DISEASE
	WELL CARE AND ADMINISTRATIVE
946	ADULT MEDICAL EXAMINATION
947	WELL CHILD CARE
948	COUNSELING
949	CONTRACEPTION AND PROCREATIVE MANAGEMENT
950	REPEAT PRESCRIPTION
951	NONSPECIFIC SIGNS & SYMPTOMS & OTHER CONTACTS WITH HLTH SVCS
959	ADMITTED OR DIED
999	ERROR

APPENDIX B

HIGHEST FREQUENCY DIAGNOSES, ENCOUNTER FILE

APPENDIX B

Highest Frequency Diagnoses, Encounter File

ICD-9-CM DX	TITLE	FREQ	PERCENT	CUMULATIVE FREQ	CUMULATIVE PERCENT
309	ADJUSTMENT REACTION	6170	3.5	6170	3.5
300	NEUROTIC DISORDERS	5948	3.4	12118	6.9
382	OTITIS MEDIA,SUPPERATIV & UNSP	5203	2.9	17321	9.8
401	ESSENTIAL HYPERTENSION	4921	2.8	22242	12.6
296	AFFECTIVE PSYCHOSES	4414	2.5	26656	15.1
477	ALLERGIC RHINITIS	4131	2.3	30787	17.4
V22	NORMAL PREGNANCY	3458	2.0	34245	19.4
786	SYMPTOMS OF RESP SYS,OTH CHEST	3412	1.9	37657	21.3
250	DIABETES MELLITUS	2935	1.7	40592	23.0
789	OTH SYMPTOMS OF ABDOMEN,PELVIS	2822	1.6	43414	24.5
465	ACUTE UPPER RESP INFECTION	2763	1.6	46177	26.1
V20	HEALTH SUPERVISN,INFANT,CHILD	2754	1.6	48931	27.7
780	GENERAL SYMPTOMS	2464	1.4	51395	29.1
462	ACUTE PHARYNGITIS	2332	1.3	53727	30.4
599	OTH DISORD,URETHRA,URINARY TRACT	2062	1.2	55789	31.5
493	ASTHMA	1979	1.1	57768	32.7
272	DISORDERS,LIPOID METABOLISM	1800	1.0	59568	33.7
414	OTH CHRONIC ISCHEMIC HEART DIS	1697	1.0	61265	34.6
724	OTH & UNSPEC DISORDERS OF BACK	1629	0.9	62894	35.6
616	INFLAMMATRY DIS CERVIX,VAGINA,VU	1535	0.9	64429	36.4
381	OTITIS MEDIA, NONSUPPURATIVE	1456	0.8	65885	37.3
490	BRONCHITIS NOT OTHERWISE SPEC	1427	0.8	67312	38.1
784	SYMPTOMS INVOLV HEAD & NECK	1427	0.8	68739	38.9
558	OTH NONINFECT GASTROENTERITIS	1362	0.8	70101	39.6
626	MENSTRUATION, OTH BLEEDING DISOR	1359	0.8	71460	40.4
V30	SINGLE LIVEBORN	1351	0.8	72811	41.2
611	OTHER DISORDERS OF BREAST	1299	0.7	74110	41.9
313	DISTURB OF EMOTIONS,CHILDHOOD	1289	0.7	75399	42.6
473	CHRONIC SINUSITIS	1208	0.7	76607	43.3
706	DISEASES OF SEBACEOUS GLANDS	1197	0.7	77804	44.0
650	NORMAL DELIVERY	1172	0.7	78976	44.7
799	OTH ILL-DEFINED,UNKNOWN CAUSES	1154	0.7	80130	45.3
610	BENIGN MAMMARY DYSPLASIAS	1114	0.6	81244	45.9
726	PERIPHERAL ENTHESOPATHIES	1103	0.6	83461	47.2
729	OTH DISORDERS OF SOFT TISSUES	1090	0.6	84551	47.8
995	CERTAIN ADVERSE EFFECTS NEC	1057	0.6	85608	48.4
692	CONTACT DERMATITIS, OTH ECZEMA	1051	0.6	86659	49.0
466	ACUTE BRONCHITIS,BRONCHIOLITIS	1033	0.6	87692	49.6
719	OTH & UNSPEC DISORD OF JOINT	999	0.6	88691	50.1
627	MENOPAUSAL,POSTMENOPAUSAL DISOR	114	0.6	82358	46.6
714	RHEUMATOID ARTHRITIS,OTH POLYAR	859	0.5	97784	55.3
715	OSTEOARTHROSIS & ALLIED DISORD	971	0.5	89662	50.7
959	INJURY, OTHER & UNSPECIFIED	930	0.5	91553	51.8
427	CARDIAC DYSRHYTHMIAS	918	0.5	92471	52.3

ICD-9-CM DX	TITLE	FREQ	PERCENT	CUMULATIVE FREQ	CUMULATIVE PERCENT
496	CHRONIC AIRWAY OBSTRUCTION NEC	916	0.5	93387	52.8
312	DISTURBANCE OF CONDUCT NEC	896	0.5	94283	53.3
174	MALIG NEOPLASM, FEMALE BREAST	891	0.5	95174	53.8
079	VIRAL INFECTION	882	0.5	96056	54.3
372	DISORDERS OF CONJUNCTIVA	851	0.5	98635	55.8
486	PNEUMONIA, ORGANISM UNSPECIFIED	961	0.5	90623	51.2
311	DEPRESSIVE DISORDER, NEC	831	0.5	99466	56.2
461	ACUTE SINUSITIS	803	0.5	100269	56.7
463	ACUTE TONSILLITIS	797	0.5	101066	57.1
625	PAIN,OTH SYMPT,FEMALE GENITAL T	869	0.5	96925	54.8
727	OTH DISORD SYNOVIUM,TENDON,BURS	725	0.4	105580	59.7
722	INTERVERTEBRAL DISC DISORDERS	771	0.4	101837	57.6
295	SCHIZOPHRENIC DISORDERS	758	0.4	103361	58.4
716	OTHER & UNSPEC ARTHROPIES	664	0.4	106948	60.5
380	DISORDERS OF EXTERNAL EAR	657	0.4	107605	60.8
367	DISORD,REFRACTION,ACCOMMODATION	751	0.4	104112	58.9
782	SKIN,OTH INTEGUMENTARY TISS SYM	704	0.4	106284	60.1
847	SPRAINS,STRAINS,OTH PARTS, BACK	743	0.4	104855	59.3
078	OTH DIS DUE TO VIRUS,CHLAMYDIA	766	0.4	102603	58.0

APPENDIX C

HIGHEST FREQUENCY PROCEDURES AND SERVICES, ENCOUNTER SAMPLE FILE

APPENDIX C

Highest Frequency Procedures and Services, Encounter Sample File

CPT-4 CODE	PROCEDURE TITLE	FREQUENCY COUNT	PERCENT OF TOTAL FREQUENCY	CUMULATIVE PERCENT
99070	SPECIAL SUPPLIES	67733	14.00	14.00
90844	INDIVIDUAL PSYCHOTHERAPY	28916	5.98	19.98
90050	OFFICE/OP VISIT, EST, LTD	26150	5.41	25.39
90060	OFFICE/OP VISIT, EST, INTERM	21349	4.41	29.80
84999	CLINICAL CHEMISTRY TEST	12836	2.65	32.45
80019	19 OR MORE BLOOD/URINE TESTS	10926	2.26	34.71
90015	OFFICE/OP VISIT, NEW, INTERM	10105	2.09	36.80
90515	EMERGENCY CARE, NEW,INTERMED	9763	2.02	38.82
76499	RADIOGRAPHIC PROCEDURE	8360	1.73	40.55
90040	OFFICE/OP VISIT, EST, BRIEF	8254	1.71	42.26
81000	URINALYSIS WITH MICROSCOPY	6913	1.43	43.69
90250	HOSPITAL VISIT, LIMITED	6792	1.40	45.09
90260	HOSPITAL VISIT, INTERMEDIATE	6498	1.34	46.43
90782	INJECTION SUBCU/(IM)	6379	1.32	47.75
90070	OFFICE/OP VISIT, EST, EXTEND	5283	1.09	48.84
95125	IMMUNOTHERAPY, MANY ANTIGENS	4924	1.02	49.86

APPENDIX D

ENCOUNTER FILE DESCRIPTION

APPENDIX D

Encounter File Description

VAR. No.	VARIABLE	TYPE	LEN	POS	FMT	DESCRIPTION
31	AAS7_1	NUM	8	127		Amount Allowed for Svc 1
54	AAS7_2	NUM	8	234		Amount Allowed for Svc 2
77	AAS7_3	NUM	8	341		Amount Allowed for Svc 3
100	AAS7_4	NUM	8	448		Amount Allowed for Svc 4
123	AAS7_5	NUM	8	555		Amount Allowed for Svc 5
146	AAS7_6	NUM	8	662		Amount Allowed for Svc 6
169	AAS7_7	NUM	8	769		Amount Allowed for Svc 7
32	ABS27_1	NUM	8	135		Amount Billed for Svc 1
55	ABS27_2	NUM	8	242		Amount Billed for Svc 2
78	ABS27_3	NUM	8	349		Amount Billed for Svc 3
101	ABS27_4	NUM	8	456		Amount Billed for Svc 4
124	ABS27_5	NUM	8	563		Amount Billed for Svc 5
147	ABS27_6	NUM	8	670		Amount Billed for Svc 6
170	ABS27_7	NUM	8	777		Amount Billed for Svc 7
8	BFC7_1	CHAR	1	56		Basis for Care
2	CBD7_1	NUM	8	8		Care Begin Date
3	CD7_1	NUM	8	16		Cycle Date
33	CED7_1	NUM	8	143		Care End Date, Svc 1
56	CED7_2	NUM	8	250		Care End Date, Svc 2
79	CED7_3	NUM	8	357		Care End Date, Svc 3
102	CED7_4	NUM	8	464		Care End Date, Svc 4
125	CED7_5	NUM	8	571		Care End Date, Svc 5
148	CED7_6	NUM	8	678		Care End Date, Svc 6
171	CED7_7	NUM	8	785		Care End Date, Svc 7
19	CEF7_1	CHAR	2	67		Care End Fiscal Year
28	CNI7_1	NUM	8	103		Internal Control No. Svc 1
51	CNI7_2	NUM	8	210		Internal Control No. Svc 2
74	CNI7_3	NUM	8	317		Internal Control No. Svc 3
97	CNI7_4	NUM	8	424		Internal Control No. Svc 4
120	CNI7_5	NUM	8	531		Internal Control No. Svc 5
143	CNI7_6	NUM	8	638		Internal Control No. Svc 6
166	CNI7_7	NUM	8	745		Internal Control No. Svc 7
20	CNSCC7_1	CHAR	2	69		Claim State/Country Code
27	CNTR_1	NUM	8	95	14.	Counter, Svc 1
50	CNTR_2	NUM	8	202	14.	Counter, Svc 2
73	CNTR_3	NUM	8	309	14.	Counter, Svc 3
96	CNTR_4	NUM	8	416	14.	Counter, Svc 4
119	CNTR_5	NUM	8	523	14.	Counter, Svc 5
142	CNTR_6	NUM	8	630	14.	Counter, Svc 6
165	CNTR_7	NUM	8	737	14.	Counter, Svc 7
29	DRN7_1	NUM	8	111		Detail Record No., Svc 1
52	DRN7_2	NUM	8	218		Detail Record No., Svc 2
75	DRN7_3	NUM	8	325		Detail Record No., Svc 3
98	DRN7_4	NUM	8	432		Detail Record No., Svc 4
121	DRN7_5	NUM	8	539		Detail Record No., Svc 5

VAR. No.	VARIABLE	TYPE	LEN	POS	FMT	DESCRIPTION
144	DRN7_6	NUM	8	646		Detail Record No., Svc 6
167	DRN7_7	NUM	8	753		Detail Record No., Svc 7
26	DX1_1	CHAR	5	90	$5.	Original diagnosis, Svc 1
49	DX1_2	CHAR	5	197	$5.	Original diagnosis, Svc 2
72	DX1_3	CHAR	5	304	$5.	Original diagnosis, Svc 3
95	DX1_4	CHAR	5	411	$5.	Original diagnosis, Svc 4
118	DX1_5	CHAR	5	518	$5.	Original diagnosis, Svc 5
141	DX1_6	CHAR	5	625	$5.	Original diagnosis, Svc 6
164	DX1_7	CHAR	5	732	$5.	Original diagnosis, Svc 7
187	DX2_1	CHAR	5	839	$5.	Recoded diagnosis, Svc 1
188	DX2_2	CHAR	5	844	$5.	Recoded diagnosis, Svc 2
189	DX2_3	CHAR	5	849	$5.	Recoded diagnosis, Svc 3
190	DX2_4	CHAR	5	854	$5.	Recoded diagnosis, Svc 4
191	DX2_5	CHAR	5	859	$5.	Recoded diagnosis, Svc 5
192	DX2_6	CHAR	5	864	$5.	Recoded diagnosis, Svc 6
193	DX2_7	CHAR	5	869	$5.	Recoded diagnosis, Svc 7
37	FBCD7_1	CHAR	1	168		FI Break Code-Detail-Svc 1
60	FBCD7_2	CHAR	1	275		FI Break Code-Detail-Svc 2
83	FBCD7_3	CHAR	1	382		FI Break Code-Detail-Svc 3
106	FBCD7_4	CHAR	1	489		FI Break Code-Detail-Svc 4
129	FBCD7_5	CHAR	1	596		FI Break Code-Detail-Svc 5
152	FBCD7_6	CHAR	1	703		FI Break Code-Detail-Svc 6
175	FBCD7_7	CHAR	1	810		FI Break Code-Detail-Svc 7
9	FDC7_1	CHAR	1	57		FI Denial Code
46	FNAME_1	CHAR	4	181		First Name - Svc 1
69	FNAME_2	CHAR	4	288		First Name - Svc 2
92	FNAME_3	CHAR	4	395		First Name - Svc 3
115	FNAME_4	CHAR	4	502		First Name - Svc 4
138	FNAME_5	CHAR	4	609		First Name - Svc 5
161	FNAME_6	CHAR	4	716		First Name - Svc 6
184	FNAME_7	CHAR	4	823		First Name - Svc 7
4	HBD7_1	NUM	8	24		Hospital Begin Date
5	HED7_1	NUM	8	32		Hospital End Date
201	I	NUM	8	930		Processing counter
36	IOC7_1	CHAR	1	167		Inpnt/Outpnt code Svc 1
59	IOC7_2	CHAR	1	274		Inpnt/outpnt code Svc 2
82	IOC7_3	CHAR	1	381		Inpnt/outpnt code Svc 3
105	IOC7_4	CHAR	1	488		Inpnt/outpnt code Svc 4
128	IOC7_5	CHAR	1	595		Inpnt/outpnt code Svc 5
151	IOC7_6	CHAR	1	702		Inpnt/outpnt code Svc 6
174	IOC7_7	CHAR	1	809		Inpnt/outpnt code Svc 7
10	MBOS7_1	CHAR	1	58		MTF Branch of Service
23	MC7_1	CHAR	3	75		Medical Treatment Facility
11	MPFC7_1	CHAR	1	59		Multi-program FY code
1	MULTFLG	NUM	8	0		Processing flag
30	NOV7_1	NUM	8	119		No. of Visits - Svc 1
53	NOV7_2	NUM	8	226		No. of Visits - Svc 2

VAR. No.	VARIABLE	TYPE	LEN	POS	FMT	DESCRIPTION
76	NOV7_3	NUM	8	333		No. of Visits - Svc 3
99	NOV7_4	NUM	8	440		No. of Visits - Svc 4
122	NOV7_5	NUM	8	547		No. of Visits - Svc 5
145	NOV7_6	NUM	8	654		No. of Visits - Svc 6
168	NOV7_7	NUM	8	761		No. of Visits - Svc 7
34	NS7_1	NUM	8	151		No. of Svcs - Svc 1
57	NS7_2	NUM	8	258		No. of Svcs - Svc 2
80	NS7_3	NUM	8	365		No. of Svcs - Svc 3
103	NS7_4	NUM	8	472		No. of Svcs - Svc 4
126	NS7_5	NUM	8	579		No. of Svcs - Svc 5
149	NS7_6	NUM	8	686		No. of Svcs - Svc 6
172	NS7_7	NUM	8	793		No. of Svcs - Svc 7
38	OBCD7_1	CHAR	1	169		OCHAMPUS Break Code-Detail 1
61	OBCD7_2	CHAR	1	276		OCHAMPUS Break Code-Detail 2
84	OBCD7_3	CHAR	1	383		OCHAMPUS Break Code-Detail 3
107	OBCD7_4	CHAR	1	490		OCHAMPUS Break Code-Detail 4
130	OBCD7_5	CHAR	1	597		OCHAMPUS Break Code-Detail 5
153	OBCD7_6	CHAR	1	704		OCHAMPUS Break Code-Detail 6
176	OBCD7_7	CHAR	1	811		OCHAMPUS Break Code-Detail 7
12	OBC7_1	CHAR	1	60		OCHAMPUS Break Code
6	OC27_1	NUM	8	40		Occurrence Count
7	PA7_1	NUM	8	48		Patient Age
42	PCC7_1	CHAR	2	173		Provider Capacity Code Svc 1
65	PCC7_2	CHAR	2	280		Provider Capacity Code Svc 2
88	PCC7_3	CHAR	2	387		Provider Capacity Code Svc 3
111	PCC7_4	CHAR	2	494		Provider Capacity Code Svc 4
134	PCC7_5	CHAR	2	601		Provider Capacity Code Svc 5
157	PCC7_6	CHAR	2	708		Provider Capacity Code Svc 6
180	PCC7_7	CHAR	2	815		Provider Capacity Code Svc 7
35	PC27_1	NUM	8	159	Z5.	Original procedure code 1
58	PC27_2	NUM	8	266	Z5.	Original procedure code 2
81	PC27_3	NUM	8	373	Z5.	Original procedure code 3
104	PC27_4	NUM	8	480	Z5.	Original procedure code 4
127	PC27_5	NUM	8	587	Z5.	Original procedure code 5
150	PC27_6	NUM	8	694	Z5.	Original procedure code 6
173	PC27_7	NUM	8	801	Z5.	Original procedure code 7
43	PMSC7_1	CHAR	2	175		Provider major specialty 1
66	PMSC7_2	CHAR	2	282		Provider major specialty 2
89	PMSC7_3	CHAR	2	389		Provider major specialty 3
112	PMSC7_4	CHAR	2	496		Provider major specialty 4
135	PMSC7_5	CHAR	2	603		Provider major specialty 5
158	PMSC7_6	CHAR	2	710		Provider major specialty 6
181	PMSC7_7	CHAR	2	817		Provider major specialty 7
40	PPF7_1	CHAR	1	171		Primary procedure flag 1
63	PPF7_2	CHAR	1	278		Primary procedure flag 2
86	PPF7_3	CHAR	1	385		Primary procedure flag 3
109	PPF7_4	CHAR	1	492		Primary procedure flag 4

VAR. No.	VARIABLE	TYPE	LEN	POS	FMT	DESCRIPTION
132	PPF7_5	CHAR	1	599		Primary procedure flag 5
155	PPF7_6	CHAR	1	706		Primary procedure flag 6
178	PPF7_7	CHAR	1	813		Primary procedure flag 7
194	PROC_1	NUM	8	874		Recoded procedure 1
195	PROC_2	NUM	8	882		Recoded procedure 2
196	PROC_3	NUM	8	890		Recoded procedure 3
197	PROC_4	NUM	8	898		Recoded procedure 4
198	PROC_5	NUM	8	906		Recoded procedure 5
199	PROC_6	NUM	8	914		Recoded procedure 6
200	PROC_7	NUM	8	922		Recoded procedure 7
13	PR7_1	CHAR	1	61		Patient Relationship
14	PS7_1	CHAR	1	62		Patient Sex
24	PZC17_1	CHAR	3	78		Patient Zip - 1st 3 pos.
21	PZC27_1	CHAR	2	71		Patient Zip - 2nd 2 pos.
41	RPC7_1	CHAR	1	172		Reason for Pricing-Svc 1
64	RPC7_2	CHAR	1	279		Reason for Pricing-Svc 2
87	RPC7_3	CHAR	1	386		Reason for Pricing-Svc 3
110	RPC7_4	CHAR	1	493		Reason for Pricing-Svc 4
133	RPC7_5	CHAR	1	600		Reason for Pricing-Svc 5
156	RPC7_6	CHAR	1	707		Reason for Pricing-Svc 6
179	RPC7_7	CHAR	1	814		Reason for Pricing-Svc 7
15	SBS7_1	CHAR	1	63		Sponsor's Branch of Service
44	SCOCC7_1	CHAR	2	177		State/Country of Care-Svc 1
67	SCOCC7_2	CHAR	2	284		State/Country of Care-Svc 2
90	SCOCC7_3	CHAR	2	391		State/Country of Care-Svc 3
113	SCOCC7_4	CHAR	2	498		State/Country of Care-Svc 4
136	SCOCC7_5	CHAR	2	605		State/Country of Care-Svc 5
159	SCOCC7_6	CHAR	2	712		State/Country of Care-Svc 6
182	SCOCC7_7	CHAR	2	819		State/Country of Care-Svc 7
47	SIC7_1	CHAR	9	185		Source of Care ID - Svc 1
70	SIC7_2	CHAR	9	292		Source of Care ID - Svc 2
93	SIC7_3	CHAR	9	399		Source of Care ID - Svc 3
116	SIC7_4	CHAR	9	506		Source of Care ID - Svc 4
139	SIC7_5	CHAR	9	613		Source of Care ID - Svc 5
162	SIC7_6	CHAR	9	720		Source of Care ID - Svc 6
185	SIC7_7	CHAR	9	827		Source of Care ID - Svc 7
16	SPC7_1	CHAR	1	64		Special Processing Code
22	SPG7_1	CHAR	2	73		Sponsor's Pay Grade
17	SRC7_1	CHAR	1	65		Special Rate Code
25	SS17_1	CHAR	9	81		Social Security No.,Sponsor
18	SS27_1	CHAR	1	66		Sponsor's Status
48	SZC17_1	CHAR	3	194		Source of Care Zip-1st 3 pos.
71	SZC17_2	CHAR	3	301		Source of Care Zip-1st 3 pos.
94	SZC17_3	CHAR	3	408		Source of Care Zip-1st 3 pos.
117	SZC17_4	CHAR	3	515		Source of Care Zip-1st 3 pos.
140	SZC17_5	CHAR	3	622		Source of Care Zip-1st 3 pos.
163	SZC17_6	CHAR	3	729		Source of Care Zip-1st 3 pos.

VAR. No.	VARIABLE	TYPE	LEN	POS	FMT	DESCRIPTION
186	SZC17_7	CHAR	3	836		Source of Care Zip-1st 3 pos.
45	SZC27_1	CHAR	2	179		Source of Care Zip-2d 2 pos.
68	SZC27_2	CHAR	2	286		Source of Care Zip-2d 2 pos.
91	SZC27_3	CHAR	2	393		Source of Care Zip-2d 2 pos.
114	SZC27_4	CHAR	2	500		Source of Care Zip-2d 2 pos.
137	SZC27_5	CHAR	2	607		Source of Care Zip-2d 2 pos.
160	SZC27_6	CHAR	2	714		Source of Care Zip-2d 2 pos.
183	SZC27_7	CHAR	2	821		Source of Care Zip-2d 2 pos.
39	TOCC7_1	CHAR	1	170		Type of Care Code - Svc 1
62	TOCC7_2	CHAR	1	277		Type of Care Code - Svc 2
85	TOCC7_3	CHAR	1	384		Type of Care Code - Svc 3
108	TOCC7_4	CHAR	1	491		Type of Care Code - Svc 4
131	TOCC7_5	CHAR	1	598		Type of Care Code - Svc 5
154	TOCC7_6	CHAR	1	705		Type of Care Code - Svc 6
177	TOCC7_7	CHAR	1	812		Type of Care Code - Svc 7

APPENDIX E

DIAGNOSIS TRANSLATION TABLE

APPENDIX E

Diagnosis Translation Table

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
V100	V1005	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF LARGE INTESTI
V101	V1011	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BRONCHUS AND
V102	V1021	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF LARYNX
V104	V1042	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF OTHER PARTS O
V105	V1051	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BLADDER
V106	V1061	PERSONAL HISTORY OF LYMPHOID LEUKEMIA
V107	V1072	PERSONAL HISTORY OF HODGKIN'S DISEASE
V108	V1082	PERSONAL HISTORY OF MALIGNANT MELANOMA OF SKIN
V158	V1589	OTHER SPECIFIED PERSONAL HISTORY PRESENTING HAZARDS TO
V250	V2509	OTHER GENERAL COUNSELING AND ADVICE ON CONTRACEPTIVE
V254	V2541	SURVEILLANCE OF CONTRACEPTIVE PILL
V300	V3000	SINGLE LIVEBORN,BORN IN HOSPITAL, NO MENT C-SECT DEL
V310	V3100	TWIN, MATE LIVEBORN,BORN IN HOSP, NO MENT C-SECT DEL
V320	V3200	TWIN, MATE STILLBRN,BORN IN HOSP, NO MENT C-SECT DEL
V330	V3300	TWIN, UNSPEC, BORN IN HOSPITAL, NO MENT C-SECT DEL
V340	V3400	OTH MULTIPLE, MATES LB, BORN IN HOSP, NO MENT C-SECT DEL
V350	V3500	OTH MULTIPLE, MATES SB, BORN IN HOSP, NO MENT C-SECT DEL
V360	V3600	OTH MULTIPLE, MATES LB & SB, BORN IN HOSP, NO MENT C-SECT
V370	V3700	OTH MULTIPLE, UNSPEC, BORN IN HOSP, NO MENT C-SECT DEL
V390	V3900	LIVEBORN NOT OTHERWISE SPEC,BORN IN HOSP, NO MENT C-SECT
V458	V4581	POSTSURGICAL AORTOCORONARY BYPASS STATUS
V578	V5789	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE
V612	V6120	PARENT-CHILD PROBLEM, UNSPECIFIED
V614	V6149	OTHER HEALTH PROBLEMS WITHIN THE FAMILY
V628	V6289	OTHER PSYCHOLOGICAL OR PHYSICAL STRESS, NOT ELSEWHERE
V675	V6759	OTHER FOLLOW-UP EXAMINATION
V688	V6881	REFERRAL OF PATIENT WITHOUT EXAMINATION OR TREATMENT
V710	V7109	OBSERVATION OF OTHER SUSPECTED MENTAL CONDITION
V764	V7649	SCREENING FOR MALIGNANT NEOPLASMS OF OTHER SITES
0032	00320	LOCALIZED SALMONELLA INFECTION, UNSPECIFIED
0084	00849	INTESTINAL INFECTION DUE TO OTHER SPECIFIED BACTERIA
0100	01000	PRIMARY TUBERCULOUS COMPLEX, UNSPECIFIED EXAMINATION
0101	01010	TUBERCULOUS PLEURISY IN PRIMARY PROGRESSIVE TUBERCULOSI
0108	01080	OTHER PRIMARY PROGRESSIVE TUBERCULOSIS, UNSPECIFIED EXA
0109	01090	PRIMARY TUBERCULOUS INFECTION, UNSPECIFIED TYPE,
0110	01100	TUBERCULOSIS OF LUNG, INFILTRATIVE, UNSPECIFIED EXAMINA
0111	01110	TUBERCULOSIS OF LUNG, NODULAR, UNSPECIFIED EXAMINATION
0112	01120	TUBERCULOSIS OF LUNG WITH CAVITATION, UNSPECIFIED EXAMI
0113	01130	TUBERCULOSIS OF BRONCHUS, UNSPECIFIED EXAMINATION
0114	01140	TUBERCULOUS FIBROSIS OF LUNG, UNSPECIFIED EXAMINATION
0115	01150	TUBERCULOUS BRONCHIECTASIS, UNSPECIFIED EXAMINATION
0116	01160	TUBERCULOUS PNEUMONIA (ANY FORM), UNSPECIFIED EXAMINATI
0117	01170	TUBERCULOUS PNEUMOTHORAX, UNSPECIFIED EXAMINATION

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
0118	01180	OTHER SPECIFIED PULMONARY TUBERCULOSIS, UNSPECIFIED
0119	01190	UNSPECIFIED PULMONARY TUBERCULOSIS, UNSPECIFIED EXAMINA
0120	01200	TUBERCULOUS PLEURISY, UNSPECIFIED EXAMINATION
0121	01210	TUBERCULOSIS OF INTRATHORACIC LYMPH NODES, UNSPECIFIED
0122	01220	ISOLATED TRACHEAL OR BRONCHIAL TUBERCULOSIS, UNSPECIFIE
0123	01230	TUBERCULOUS LARYNGITIS, UNSPECIFIED EXAMINATION
0128	01280	OTHER SPECIFIED RESPIRATORY TUBERCULOSIS, UNSPECIFIED
0130	01300	TUBERCULOUS MENINGITIS, UNSPECIFIED EXAMINATION
0131	01310	TUBERCULOMA OF MENINGES, UNSPECIFIED EXAMINATION
0132	01320	TUBERCULOMA OF BRAIN, UNSPECIFIED EXAMINATION
0133	01330	TUBERCULOUS ABSCESS OF BRAIN, UNSPECIFIED EXAMINATION
0134	01340	TUBERCULOMA OF SPINAL CORD, UNSPECIFIED EXAMINATION
0135	01350	TUBERCULOUS ABSCESS OF SPINAL CORD, UNSPECIFIED EXAMINA
0136	01360	TUBERCULOUS ENCEPHALITIS OR MYELITIS, UNSPECIFIED EXAMI
0138	01380	OTHER SPECIFIED TUBERCULOSIS OF CENTRAL NERVOUS SYSTEM,
0139	01390	UNSPECIFIED TUBERCULOSIS OF CENTRAL NERVOUS SYSTEM,
0140	01400	TUBERCULOUS PERITONITIS, UNSPECIFIED EXAMINATION
0148	01480	TUBERCULOSIS OF INTESTINES AND MESENTERIC GLANDS, UNSPE
0150	01500	TUBERCULOSIS OF VERTEBRAL COLUMN, UNSPECIFIED EXAMINATI
0151	01510	TUBERCULOSIS OF HIP, UNSPECIFIED EXAMINATION
0152	01520	TUBERCULOSIS OF KNEE, UNSPECIFIED EXAMINATION
0155	01550	TUBERCULOSIS OF LIMB BONES, UNSPECIFIED EXAMINATION
0156	01560	TUBERCULOSIS OF MASTOID, UNSPECIFIED EXAMINATION
0157	01570	TUBERCULOSIS OF OTHER SPECIFIED BONE, UNSPECIFIED EXAMI
0158	01580	TUBERCULOSIS OF OTHER SPECIFIED JOINT, UNSPECIFIED EXAM
0159	01590	TUBERCULOSIS OF UNSPECIFIED BONES AND JOINTS,
0160	01600	TUBERCULOSIS OF KIDNEY, UNSPECIFIED EXAMINATION
0161	01610	TUBERCULOSIS OF BLADDER, UNSPECIFIED EXAMINATION
0162	01620	TUBERCULOSIS OF URETER, UNSPECIFIED EXAMINATION
0163	01630	TUBERCULOSIS OF OTHER URINARY ORGANS, UNSPECIFIED EXAMI
0164	01640	TUBERCULOSIS OF EPIDIDYMIS, UNSPECIFIED EXAMINATION
0165	01650	TUBERCULOSIS OF OTHER MALE GENITAL ORGANS,
0166	01660	TUBERCULOUS OOPHORITIS AND SALPINGITIS, UNSPECIFIED EXA
0167	01670	TUBERCULOSIS OF OTHER FEMALE GENITAL ORGANS,
0169	01690	UNSPECIFIED GENITOURINARY TUBERCULOSIS, UNSPECIFIED EXA
0170	01700	TUBERCULOSIS OF SKIN AND SUBCUTANEOUS CELLULAR TISSUE,
0171	01710	ERYTHEMA NODOSUM WITH HYPERSENSITIVITY REACTION IN
0172	01720	TUBERCULOSIS OF PERIPHERAL LYMPH NODES, UNSPECIFIED EXA
0173	01730	TUBERCULOSIS OF EYE, UNSPECIFIED EXAMINATION
0174	01740	TUBERCULOSIS OF EAR, UNSPECIFIED EXAMINATION
0175	01750	TUBERCULOSIS OF THYROID GLAND, UNSPECIFIED ORIGIN
0176	01760	TUBERCULOSIS OF ADRENAL GLANDS, UNSPECIFIED EXAMINATION
0177	01770	TUBERCULOSIS OF SPLEEN, UNSPECIFIED EXAMINATION
0178	01780	TUBERCULOSIS OF ESOPHAGUS, UNSPECIFIED EXAMINATION
0179	01790	TUBERCULOSIS OF OTHER SPECIFIED ORGANS, UNSPECIFIED EXA
0180	01800	ACUTE MILIARY TUBERCULOSIS, UNSPECIFIED EXAMINATION
0188	01880	OTHER SPECIFIED MILIARY TUBERCULOSIS, UNSPECIFIED EXAMI

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
0189	01890	UNSPECIFIED MILIARY TUBERCULOSIS, UNSPECIFIED EXAMINATI
0328	03289	OTHER SPECIFIED DIPHTHERIA
0364	03640	MENINGOCOCCAL CARDITIS, UNSPECIFIED
0368	03689	OTHER SPECIFIED MENINGOCOCCAL INFECTIONS
0384	03840	SEPTICEMIA DUE TO GRAM-NEGATIVE ORGANISM, UNSPECIFIED
0408	04089	OTHER SPECIFIED BACTERIAL DISEASES
0450	04500	ACUTE PARALYTIC POLIOMYELITIS SPECIFIED AS BULBAR,
0451	04510	ACUTE POLIOMYELITIS WITH OTHER PARALYSIS, UNSPECIFIED T
0452	04520	ACUTE NONPARALYTIC POLIOMYELITIS,
0459	04590	UNSPECIFIED ACUTE POLIOMYELITIS, UNSPECIFIED TYPE POLIO
0531	05312	POSTHERPETIC TRIGEMINAL NEURALGIA
0532	05329	HERPES ZOSTER WITH OTHER OPHTHALMIC COMPLICATIONS
0537	05379	HERPES ZOSTER WITH OTHER SPECIFIED COMPLICATIONS
0541	05410	GENITAL HERPES, UNSPECIFIED
0544	05443	HERPES SIMPLEX DISCIFORM KERATITIS
0547	05479	HERPES SIMPLEX WITH OTHER SPECIFIED COMPLICATIONS
0557	05579	MEASLES WITH OTHER SPECIFIED COMPLICATIONS
0560	05600	RUBELLA WITH UNSPECIFIED NEUROLOGICAL COMPLICATION
0567	05679	RUBELLA WITH OTHER SPECIFIED COMPLICATIONS
0727	07279	MUMPS WITH OTHER SPECIFIED COMPLICATIONS
0742	07420	COXSACKIE CARDITIS, UNSPECIFIED
0788	07889	OTHER SPECIFIED DISEASES DUE TO VIRUSES AND CHLAMYDIAE
0888	08889	OTHER SPECIFIED ARTHROPOD-BORNE DISEASE
0904	09040	JUVENILE NEUROSYPHILIS, UNSPECIFIED
0915	09150	SYPHILITIC UVEITIS, UNSPECIFIED
0916	09169	SECONDARY SYPHILIS OF OTHER VISCERA
0918	09189	OTHER FORMS OF SECONDARY SYPHILIS
0932	09320	SYPHILITIC ENDOCARDITIS OF VALVE, UNSPECIFIED
0938	09389	OTHER SPECIFIED CARDIOVASCULAR SYPHILIS
0948	09489	OTHER SPECIFIED NEUROSYPHILIS
0981	09810	GONOCOCCAL INFECTION (ACUTE) OF UPPER GENITOURINARY
0983	09830	CHRONIC GONOCOCCAL INFECTION OF UPPER GENITOURINARY
0984	09849	OTHER GONOCOCCAL INFECTION OF EYE
0985	09859	OTHER GONOCOCCAL INFECTION OF JOINT
0988	09889	GONOCOCCAL INFECTION OF OTHER SPECIFIED SITES
1008	10089	OTHER SPECIFIED LEPTOSPIRAL INFECTIONS
1128	11289	OTHER CANDIDIASIS OF OTHER SPECIFIED SITES
1150	11500	INFECTION BY HISTOPLASMA CAPSULATUM, WITHOUT MENTION OF
1151	11510	INFECTION BY HISTOPLASMA DUBOISII, WITHOUT MENTION OF
1159	11590	HISTOPLASMOSIS, UNSPECIFIED WITHOUT MENTION OF MANIFEST
1310	13101	TRICHOMONAL VULVOVAGINITIS
1988	19882	SECONDARY MALIGNANT NEOPLASM OF GENITAL ORGANS
2000	20000	RETICULOSARCOMA, UNSPECIFIED SITE
2001	20010	LYMPHOSARCOMA, UNSPECIFIED SITE
2002	20020	BURKITT'S TUMOR OR LYMPHOMA, UNSPECIFIED SITE
2008	20080	OTHER NAMED VARIANTS OF LYMPHOSARCOMA AND RETICULOSARCO
2010	20100	HODGKIN'S PARAGRANULOMA, UNSPECIFIED SITE

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
2011	20110	HODGKIN'S GRANULOMA, UNSPECIFIED SITE
2012	20120	HODGKIN'S SARCOMA, UNSPECIFIED SITE
2014	20140	HODGKIN'S DISEASE, LYMPHOCYTIC-HISTIOCYTIC PREDOMINANCE
2015	20150	HODGKIN'S DISEASE, NODULAR SCLEROSIS, UNSPECIFIED SITE
2016	20160	HODGKIN'S DISEASE, MIXED CELLULARITY, UNSPECIFIED SITE
2017	20170	HODGKIN'S DISEASE, LYMPHOCYTIC DEPLETION, UNSPECIFIED S
2019	20190	HODGKIN'S DISEASE, UNSPECIFIED TYPE, UNSPECIFIED SITE
2020	20200	NODULAR LYMPHOMA, UNSPECIFIED SITE
2021	20210	MYCOSIS FUNGOIDES, UNSPECIFIED SITE
2022	20220	SEZARY'S DISEASE, UNSPECIFIED SITE
2023	20230	MALIGNANT HISTIOCYTOSIS, UNSPECIFIED SITE
2024	20240	LEUKEMIC RETICULOENDOTHELIOSIS, UNSPECIFIED SITE
2025	20250	LETTERER-SIWE DISEASE, UNSPECIFIED SITE
2026	20260	MALIGNANT MAST CELL TUMORS, UNSPECIFIED SITE
2028	20280	OTHER MALIGNANT LYMPHOMAS, UNSPECIFIED SITE
2029	20290	OTHER AND UNSPECIFIED MALIGNANT NEOPLASMS OF LYMPHOID
2238	22381	BENIGN NEOPLASM OF URETHRA
2280	22800	HEMANGIOMA OF UNSPECIFIED SITE
2369	23690	NEOPLASM OF UNCERTAIN BEHAVIOR OF URINARY ORGAN, UNSPEC
2420	24200	TOXIC DIFFUSE GOITER WITHOUT MENTION OF THYROTOXIC CRIS
2421	24210	TOXIC UNINODULAR GOITER WITHOUT MENTION OF THYROTOXIC C
2422	24220	TOXIC MULTINODULAR GOITER WITHOUT MENTION OF THYROTOXIC
2423	24230	TOXIC NODULAR GOITER, UNSPECIFIED TYPE, WITHOUT MENTION
2424	24240	THYROTOXICOSIS FROM ECTOPIC THYROID NODULE WITHOUT MENT
2428	24280	THYROTOXICOSIS OF OTHER SPECIFIED ORIGIN WITHOUT MENTIO
2429	24290	THYROTOXICOSIS WITHOUT MENTION OF GOITER OR OTHER CAUSE
2500	25000	ADULT-ONSET TYPE DIABETES MELLITUS WITHOUT MENTION OF
2501	25010	ADULT-ONSET TYPE DIABETES MELLITUS WITH KETOACIDOSIS
2502	25020	ADULT-ONSET TYPE DIABETES MELLITUS WITH HYPEROSMOLAR CO
2503	25030	ADULT-ONSET TYPE DIABETES MELLITUS WITH OTHER COMA
2504	25040	ADULT-ONSET TYPE DIABETES MELLITUS WITH RENAL MANIFESTA
2505	25050	ADULT-ONSET TYPE DIABETES MELLITUS WITH OPHTHALMIC
2506	25060	ADULT-ONSET TYPE DIABETES MELLITUS WITH NEUROLOGICAL
2507	25070	ADULT-ONSET TYPE DIABETES MELLITUS WITH PERIPHERAL CIRC
2508	25080	ADULT-ONSET TYPE DIABETES MELLITUS WITH OTHER SPECIFIED
2509	25090	ADULT-ONSET TYPE DIABETES MELLITUS WITH UNSPECIFIED COM
2741	27410	GOUTY NEPHROPATHY, UNSPECIFIED
2748	27489	GOUT WITH OTHER SPECIFIED MANIFESTATIONS
2770	27700	CYSTIC FIBROSIS WITHOUT MENTION OF MECONIUM ILEUS
2790	27901	SELECTIVE IGA IMMUNODEFICIENCY
2791	27919	OTHER DEFICIENCY OF CELL-MEDIATED IMMUNITY
2826	28262	HB-S DISEASE WITH MENTION OF CRISIS
2895	28959	OTHER DISEASES OF SPLEEN
2901	29010	PRESENILE DEMENTIA, UNCOMPLICATED
2902	29021	SENILE DEMENTIA WITH DEPRESSIVE FEATURES
2904	29040	ARTERIOSCLEROTIC DEMENTIA, UNCOMPLICATED
2921	29211	DRUG-INDUCED ORGANIC DELUSIONAL SYNDROME

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2928	29284	DRUG-INDUCED ORGANIC AFFECTIVE SYNDROME
2938	29389	OTHER SPECIFIED TRANSIENT ORGANIC MENTAL DISORDERS
2950	29500	SIMPLE TYPE SCHIZOPHRENIA, UNSPECIFIED STATE
2951	29512	DISORGANIZED TYPE SCHIZOPHRENIA, CHRONIC STATE
2952	29520	CATATONIC TYPE SCHIZOPHRENIA, UNSPECIFIED STATE
2953	29530	PARANOID TYPE SCHIZOPHRENIA, UNSPECIFIED STATE
2954	29540	ACUTE SCHIZOPHRENIC EPISODE, UNSPECIFIED STATE
2955	29550	LATENT SCHIZOPHRENIA, UNSPECIFIED STATE
2956	29562	RESIDUAL SCHIZOPHRENIA, CHRONIC STATE
2957	29570	SCHIZO-AFFECTIVE TYPE SCHIZOPHRENIA, UNSPECIFIED STATE
2958	29580	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA, UNSPECIFIED STA
2959	29590	UNSPECIFIED TYPE SCHIZOPHRENIA, UNSPECIFIED STATE
2960	29600	MANIC AFFECTIVE DISORDER, SINGLE EPISODE, UNSPECIFIED D
2961	29610	MANIC AFFECTIVE DISORDER, RECURRENT EPISODE, UNSPECIFIE
2962	29620	MAJOR DEPRESSIVE AFFECTIVE DISORDER, SINGLE EPISODE,
2963	29630	MAJOR DEPRESSIVE AFFECTIVE DISORDER, RECURRENT EPISODE,
2964	29640	BIPOLAR AFFECTIVE DISORDER, MANIC, UNSPECIFIED DEGREE
2965	29650	BIPOLAR AFFECTIVE DISORDER, DEPRESSED, UNSPECIFIED DEGR
2966	29660	BIPOLAR AFFECTIVE DISORDER, MIXED, UNSPECIFIED DEGREE
2968	29680	MANIC-DEPRESSIVE PSYCHOSIS, UNSPECIFIED
2969	29690	UNSPECIFIED AFFECTIVE PSYCHOSIS
2990	29900	INFANTILE AUTISM, CURRENT OR ACTIVE STATE
2991	29910	DISINTEGRATIVE PSYCHOSIS, CURRENT OR ACTIVE STATE
2998	29980	OTHER SPECIFIED EARLY CHILDHOOD PSYCHOSES, CURRENT OR A
2999	29990	UNSPECIFIED CHILDHOOD PSYCHOSIS, CURRENT OR ACTIVE STAT
3000	30000	ANXIETY STATE, UNSPECIFIED
3001	30011	CONVERSION DISORDER
3002	30021	AGORAPHOBIA WITH PANIC ATTACKS
3008	30089	OTHER NEUROTIC DISORDERS
3011	30113	CYCLOTHYMIC DISORDER
3012	30120	SCHIZOID PERSONALITY DISORDER, UNSPECIFIED
3015	30150	HISTRIONIC PERSONALITY DISORDER, UNSPECIFIED
3018	30183	BORDERLINE PERSONALITY
3025	30250	TRANS-SEXUALISM WITH UNSPECIFIED SEXUAL HISTORY
3027	30272	PSYCHOSEXUAL DYSFUNCTION WITH INHIBITED SEXUAL EXCITEME
3028	30281	FETISHISM
3030	30302	ACUTE ALCOHOLIC INTOXICATION IN ALCOHOLISM, EPISODIC
3039	30390	OTHER AND UNSPECIFIED ALCOHOL DEPENDENCE, UNSPECIFIED
3040	30400	OPIOID TYPE DEPENDENCE, UNSPECIFIED USE
3041	30410	BARBITURATE AND SIMILARLY ACTING SEDATIVE OR HYPNOTIC
3042	30420	COCAINE DEPENDENCE, UNSPECIFIED USE
3043	30430	CANNABIS DEPENDENCE, UNSPECIFIED USE
3044	30440	AMPHETAMINE AND OTHER PSYCHOSTIMULANT DEPENDENCE,
3045	30450	HALLUCINOGEN DEPENDENCE, UNSPECIFIED USE
3046	30461	OTHER SPECIFIED DRUG DEPENDENCE, CONTINUOUS USE
3047	30470	COMBINATIONS OF OPIOID TYPE DRUG WITH ANY OTHER DRUG
3048	30480	COMBINATIONS OF DRUG DEPENDENCE EXCLUDING OPIOID

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3049	30490	UNSPECIFIED DRUG DEPENDENCE, UNSPECIFIED USE
3050	30500	ALCOHOL ABUSE, UNSPECIFIED DRINKING BEHAVIOR
3051	30510	TOBACCO USE DISORDER, UNSPECIFIED USE
3052	30520	CANNABIS ABUSE, UNSPECIFIED USE
3053	30530	HALLUCINOGEN ABUSE, UNSPECIFIED USE
3054	30540	BARBITURATE AND SIMILARLY ACTING SEDATIVE OR
3055	30550	OPIOID ABUSE, UNSPECIFIED USE
3056	30561	COCAINE ABUSE, CONTINUOUS USE
3057	30570	AMPHETAMINE OR RELATED ACTING SYMPATHOMIMETIC ABUSE,
3058	30580	ANTIDEPRESSANT TYPE ABUSE, UNSPECIFIED USE
3059	30590	OTHER, MIXED, OR UNSPECIFIED DRUG ABUSE, UNSPECIFIED US
3065	30650	PSYCHOGENIC GENITOURINARY MALFUNCTION, UNSPECIFIED
3072	30723	GILLES DE LA TOURETTE'S DISORDER
3074	30747	OTHER DYSFUNCTIONS OF SLEEP STAGES OR AROUSAL FROM SLEE
3075	30750	EATING DISORDER, UNSPECIFIED
3078	30781	TENSION HEADACHE
3092	30928	ADJUSTMENT REACTION WITH MIXED EMOTIONAL FEATURES
3098	30981	PROLONGED POSTTRAUMATIC STRESS DISORDER
3120	31200	UNDERSOCIALIZED CONDUCT DISORDER, AGGRESSIVE TYPE,
3121	31210	UNDERSOCIALIZED CONDUCT DISORDER, UNAGGRESSIVE TYPE,
3122	31221	SOCIALIZED CONDUCT DISORDER, MILD DEGREE
3123	31230	IMPULSE CONTROL DISORDER, UNSPECIFIED
3132	31322	INTROVERTED DISORDER OF CHILDHOOD
3138	31382	IDENTITY DISORDER OF CHILDHOOD OR ADOLESCENCE
3140	31400	ATTENTION DEFICIT DISORDER OF CHILDHOOD WITHOUT MENTION
3150	31500	DEVELOPMENTAL READING DISORDER, UNSPECIFIED
3153	31539	OTHER DEVELOPMENTAL SPEECH DISORDER
3318	33181	REYE'S SYNDROME
3338	33381	BLEPHAROSPASM
3339	33390	UNSPECIFIED EXTRAPYRAMIDAL DISEASE AND ABNORMAL
3351	33510	SPINAL MUSCULAR ATROPHY, UNSPECIFIED
3352	33520	AMYOTROPHIC LATERAL SCLEROSIS
3446	34461	CAUDA EQUINA SYNDROME WITH NEUROGENIC BLADDER
3450	34500	GENERALIZED NONCONVULSIVE EPILEPSY,WO MENT INTRACT EPILEPSY
3451	34510	GENERALIZED CONVULSIVE EPILEPSY, WO MENT INTRACT EPILEPSY
3454	34540	PARTIAL EPILEPSY, W/CONSCIOUSNESS IMPAIRMT,WO MENT INTR EPI
3455	34550	PARTIAL EPILEPSY, WO CONSCIOUSNESS IMPRMT, WO MENT INTR EPI
3456	34560	INFANTILE SPASMS, WO MENT INTRACT EPILEPSY
3457	34570	EPILEPSIA PARTIALIS CONTINUA, WO MENT INTRACT EPILEPSY
3458	34580	OTH FORMS OF EPILEPSY, WO MENT INTRACT EPILEPSY
3459	34590	EPILEPSY, UNSPECIFIED, WO MENT INTRACT EPILEPSY
3498	34989	OTHER SPECIFIED DISORDERS OF NERVOUS SYSTEM
3600	36000	PURULENT ENDOPHTHALMITIS, UNSPECIFIED
3601	36019	OTHER ENDOPHTHALMITIS
3602	36021	PROGRESSIVE HIGH (DEGENERATIVE) MYOPIA
3603	36030	HYPOTONY OF EYE, UNSPECIFIED
3604	36043	HEMOPHTHALMOS, EXCEPT CURRENT INJURY

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3605	36050	FOREIGN BODY, MAGNETIC, INTRAOCULAR, UNSPECIFIED
3606	36060	FOREIGN BODY, INTRAOCULAR, UNSPECIFIED
3608	36089	OTHER DISORDERS OF GLOBE
3610	36100	RETINAL DETACHMENT WITH RETINAL DEFECT, UNSPECIFIED
3611	36110	RETINOSCHISIS, UNSPECIFIED
3613	36130	RETINAL DEFECT, UNSPECIFIED
3618	36189	OTHER FORMS OF RETINAL DETACHMENT
3620	36201	BACKGROUND DIABETIC RETINOPATHY
3621	36211	HYPERTENSIVE RETINOPATHY
3622	36221	RETROLENTAL FIBROPLASIA
3623	36234	TRANSIENT RETINAL ARTERIAL OCCLUSION
3624	36241	CENTRAL SEROUS RETINOPATHY
3625	36250	MACULAR DEGENERATION (SENILE) OF RETINA, UNSPECIFIED
3626	36263	LATTICE DEGENERATION OF RETINA
3627	36274	PIGMENTARY RETINAL DYSTROPHY
3628	36281	RETINAL HEMORRHAGE
3630	36300	FOCAL CHORIORETINITIS, UNSPECIFIED
3631	36315	DISSEMINATED RETINITIS AND RETINOCHOROIDITIS, PIGMENT
3632	36320	CHORIORETINITIS, UNSPECIFIED
3633	36332	OTHER MACULAR SCARS OF RETINA
3634	36341	SENILE ATROPHY OF CHOROID
3635	36350	HEREDITARY CHOROIDAL DYSTROPHY OR ATROPHY, UNSPECIFIED
3636	36363	CHOROIDAL RUPTURE
3637	36370	CHOROIDAL DETACHMENT, UNSPECIFIED
3640	36400	ACUTE AND SUBACUTE IRIDOCYCLITIS, UNSPECIFIED
3641	36410	CHRONIC IRIDOCYCLITIS, UNSPECIFIED
3642	36422	GLAUCOMATOCYCLITIC CRISES
3644	36441	HYPHEMA OF IRIS AND CILIARY BODY
3645	36453	PIGMENTARY IRIS DEGENERATION
3646	36460	IDIOPATHIC CYSTS OF IRIS AND CILIARY BODY
3647	36471	POSTERIOR SYNECHIAE OF IRIS
3650	36504	OCULAR HYPERTENSION
3651	36511	PRIMARY OPEN ANGLE GLAUCOMA
3652	36520	PRIMARY ANGLE-CLOSURE GLAUCOMA, UNSPECIFIED
3653	36532	CORTICOSTEROID-INDUCED GLAUCOMA, RESIDUAL STAGE
3654	36544	GLAUCOMA ASSOCIATED WITH SYSTEMIC SYNDROMES
3655	36559	GLAUCOMA ASSOCIATED WITH OTHER LENS DISORDERS
3656	36560	GLAUCOMA ASSOCIATED WITH UNSPECIFIED OCULAR DISORDER
3658	36589	OTHER SPECIFIED GLAUCOMA
3660	36603	CORTICAL, LAMELLAR, OR ZONULAR NONSENILE CATARACT
3661	36616	SENILE NUCLEAR SCLEROSIS
3662	36620	TRAUMATIC CATARACT, UNSPECIFIED
3663	36630	CATARACTA COMPLICATA, UNSPECIFIED
3664	36644	CATARACT ASSOCIATED WITH OTHER SYNDROMES
3665	36650	AFTER-CATARACT, UNSPECIFIED
3672	36720	ASTIGMATISM, UNSPECIFIED
3673	36731	ANISOMETROPIA

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
3675	36753	SPASM OF ACCOMMODATION
3678	36781	TRANSIENT REFRACTIVE CHANGE
3680	36800	AMBLYOPIA, UNSPECIFIED
3681	36813	VISUAL DISCOMFORT
3683	36830	BINOCULAR VISION DISORDER, UNSPECIFIED
3684	36846	HOMONYMOUS BILATERAL FIELD DEFECTS
3685	36859	OTHER COLOR VISION DEFICIENCIES
3686	36869	OTHER NIGHT BLINDNESS
3690	36900	BLINDNESS OF BOTH EYES, IMPAIRMENT LEVEL NOT FURTHER SP
3691	36910	BLINDNESS, ONE EYE; LOW VISION OTHER EYE
3692	36925	BETTER EYE: MODERATE VISION IMPAIRMENT;
3696	36960	BLINDNESS, ONE EYE, NOT OTHERWISE SPECIFIED
3697	36970	LOW VISION, ONE EYE, NOT OTHERWISE SPECIFIED
3700	37000	CORNEAL ULCER, UNSPECIFIED
3702	37021	PUNCTATE KERATITIS
3703	37033	KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S
3704	37040	KERATOCONJUNCTIVITIS, UNSPECIFIED
3705	37050	INTERSTITIAL KERATITIS, UNSPECIFIED
3706	37060	CORNEAL NEOVASCULARIZATION, UNSPECIFIED
3710	37100	CORNEAL OPACITY, UNSPECIFIED
3711	37113	POSTERIOR CORNEAL PIGMENTATIONS
3712	37120	CORNEAL EDEMA, UNSPECIFIED
3713	37130	CORNEAL MEMBRANE CHANGE, UNSPECIFIED
3714	37142	RECURRENT EROSION OF CORNEA
3715	37157	ENDOTHELIAL CORNEAL DYSTROPHY
3716	37160	KERATOCONUS, UNSPECIFIED
3717	37170	CORNEAL DEFORMITY, UNSPECIFIED
3718	37189	OTHER CORNEAL DISORDERS
3720	37205	ACUTE ATOPIC CONJUNCTIVITIS
3721	37214	OTHER CHRONIC ALLERGIC CONJUNCTIVITIS
3722	37220	BLEPHAROCONJUNCTIVITIS, UNSPECIFIED
3723	37230	CONJUNCTIVITIS, UNSPECIFIED
3724	37240	PTERYGIUM, UNSPECIFIED
3725	37251	PINGUECULA
3726	37264	SCARRING OF CONJUNCTIVA
3727	37272	CONJUNCTIVAL HEMORRHAGE
3730	37300	BLEPHARITIS, UNSPECIFIED
3731	37311	HORDEOLUM EXTERNUM
3733	37331	ECZEMATOUS DERMATITIS OF EYELID
3740	37400	ENTROPION, UNSPECIFIED
3741	37410	ECTROPION, UNSPECIFIED
3742	37420	LAGOPHTHALMOS, UNSPECIFIED
3743	37430	PTOSIS OF EYELID, UNSPECIFIED
3744	37445	OTHER SENSORIMOTOR DISORDERS OF EYELID
3745	37456	OTHER DEGENERATIVE DISORDERS OF SKIN AFFECTING EYELID
3748	37489	OTHER DISORDERS OF EYELID
3750	37500	DACRYOADENITIS, UNSPECIFIED

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
3751	37515	TEAR FILM INSUFFICIENCY, UNSPECIFIED
3752	37520	EPIPHORA, UNSPECIFIED AS TO CAUSE
3753	37530	DACRYOCYSTITIS, UNSPECIFIED
3754	37541	CHRONIC CANALICULITIS
3755	37556	STENOSIS OF NASOLACRIMAL DUCT, ACQUIRED
3756	37569	OTHER CHANGES OF LACRIMAL PASSAGES
3758	37589	OTHER DISORDERS OF LACRIMAL SYSTEM
3760	37601	ORBITAL CELLULITIS
3761	37611	ORBITAL GRANULOMA
3762	37621	THYROTOXIC EXOPHTHALMOS
3763	37630	EXOPHTHALMOS, UNSPECIFIED
3764	37640	DEFORMITY OF ORBIT, UNSPECIFIED
3765	37652	ENOPHTHALMOS DUE TO TRAUMA OR SURGERY
3768	37681	ORBITAL CYSTS
3770	37700	PAPILLEDEMA, UNSPECIFIED
3771	37710	OPTIC ATROPHY, UNSPECIFIED
3772	37721	DRUSEN OF OPTIC DISC
3773	37730	OPTIC NEURITIS, UNSPECIFIED
3774	37741	ISCHEMIC OPTIC NEUROPATHY
3775	37754	DISORDERS OF OPTIC CHIASM ASSOCIATED WITH INFLAMMATORY
3776	37761	DISORDERS OF OTHER VISUAL PATHWAYS ASSOCIATED WITH NEOP
3777	37771	DISORDERS OF VISUAL CORTEX ASSOCIATED WITH NEOPLASMS
3780	37805	ALTERNATING ESOTROPIA
3781	37810	EXOTROPIA, UNSPECIFIED
3782	37820	INTERMITTENT HETEROTROPIA, UNSPECIFIED
3783	37835	ACCOMMODATIVE COMPONENT IN ESOTROPIA
3784	37842	EXOPHORIA
3785	37851	THIRD OR OCULOMOTOR NERVE PALSY, PARTIAL
3786	37860	MECHANICAL STRABISMUS, UNSPECIFIED
3787	37871	DUANE'S SYNDROME
3788	37883	CONVERGENCE INSUFFICIENCY OR PALSY
3790	37900	SCLERITIS, UNSPECIFIED
3791	37919	OTHER SCLERAL DISORDERS
3792	37924	OTHER VITREOUS OPACITIES
3793	37931	APHAKIA
3794	37942	MIOSIS (PERSISTENT), NOT DUE TO MIOTICS
3795	37950	NYSTAGMUS, UNSPECIFIED
3799	37999	OTHER ILL-DEFINED DISORDERS OF EYE
3800	38000	PERICHONDRITIS OF PINNA, UNSPECIFIED
3801	38010	INFECTIVE OTITIS EXTERNA, UNSPECIFIED
3802	38023	OTHER CHRONIC OTITIS EXTERNA
3803	38039	OTHER NONINFECTIOUS DISORDERS OF PINNA
3805	38050	ACQUIRED STENOSIS OF EXTERNAL EAR CANAL, UNSPECIFIED
3808	38089	OTHER DISORDERS OF EXTERNAL EAR
3810	38101	ACUTE SEROUS OTITIS MEDIA
3811	38110	CHRONIC SEROUS OTITIS MEDIA, SIMPLE OR UNSPECIFIED
3812	38120	CHRONIC MUCOID OTITIS MEDIA, SIMPLE OR UNSPECIFIED

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
3815	38150	EUSTACHIAN SALPINGITIS, UNSPECIFIED
3816	38160	OBSTRUCTION OF EUSTACHIAN TUBE, UNSPECIFIED
3818	38181	DYSFUNCTION OF EUSTACHIAN TUBE
3820	38200	ACUTE SUPPURATIVE OTITIS MEDIA WITHOUT SPONTANEOUS RUPT
3830	38300	ACUTE MASTOIDITIS WITHOUT COMPLICATIONS
3832	38320	PETROSITIS, UNSPECIFIED
3833	38330	POSTMASTOIDECTOMY COMPLICATION, UNSPECIFIED
3838	38389	OTHER DISORDERS OF MASTOID
3840	38400	ACUTE MYRINGITIS, UNSPECIFIED
3842	38420	PERFORATION OF TYMPANIC MEMBRANE, UNSPECIFIED
3848	38481	ATROPHIC FLACCID TYMPANIC MEMBRANE
3850	38500	TYMPANOSCLEROSIS, UNSPECIFIED AS TO INVOLVEMENT
3851	38510	ADHESIVE MIDDLE EAR DISEASE, UNSPECIFIED AS TO INVOLVEM
3852	38523	DISCONTINUITY OR DISLOCATION OF EAR OSSICLES
3853	38530	CHOLESTEATOMA, UNSPECIFIED
3858	38589	OTHER DISORDERS OF MIDDLE EAR AND MASTOID
3860	38600	MENIERE'S DISEASE, UNSPECIFIED
3861	38611	BENIGN PAROXYSMAL POSITIONAL VERTIGO
3863	38630	LABYRINTHITIS, UNSPECIFIED
3864	38640	LABYRINTHINE FISTULA, UNSPECIFIED
3865	38650	LABYRINTHINE DYSFUNCTION, UNSPECIFIED
3880	38801	PRESBYACUSIS
3881	38812	NOISE-INDUCED HEARING LOSS
3883	38830	TINNITUS, UNSPECIFIED
3884	38840	ABNORMAL AUDITORY PERCEPTION, UNSPECIFIED
3886	38860	OTORRHEA, UNSPECIFIED
3887	38870	OTALGIA, UNSPECIFIED
3890	38900	CONDUCTIVE HEARING LOSS, UNSPECIFIED
3891	38910	SENSORINEURAL HEARING LOSS, UNSPECIFIED
3989	39890	RHEUMATIC HEART DISEASE, UNSPECIFIED
4020	40200	HYPERTENSIVE HEART DIS, MALIGNANT, WO CONGESTIVE HEART FLR
4021	40210	HYPERTENSIVE HEART DIS, BENIGN, WO CONGESTIVE HEART FAILURE
4029	40290	UNSPECIFIED HYPERTENSIVE HEART DISEASE WITHOUT CONGESTI
4030	40300	HYPERTENSIVE RENAL DIS, MALIGNANT, WO MENT OF RENAL FAILURE
4031	40310	HYPERTENSIVE RENAL DIS, BENIGN, WO MENT OF RENAL FAILURE
4039	40390	HYPERTENSIVE RENAL DIS, UNSPEC, WO MENT OF RENAL FAILURE
4040	40400	HYPERTNSV HEART & RENAL DIS,MALIGNANT,WO MENT HRT,RENL FLR
4041	40410	HYPERTNSV HEART & RENAL DIS,BENIGN,WO MENT HRT, RENL FLR
4049	40490	HYPERTNSV HEART & RENAL DIS,UNSPEC,WO MENT HRT,RENL FLR
4050	40509	OTHER MALIGNANT SECONDARY HYPERTENSION
4051	40519	OTHER BENIGN SECONDARY HYPERTENSION
4059	40591	UNSPECIFIED RENOVASCULAR HYPERTENSION
4100	41000	ACUTE MYOCARDIAL INFARCTION, EPISODE OF CARE UNSPECIFIED
4101	41010	ACUTE MYOCARDIAL INFARCTION OF OTH ANTERIOR WALL, NOS
4102	41020	ACUTE MYOCARDIAL INFARCTION, INFEROLATERAL WALL, NOS
4103	41030	ACUTE MYOCARDIAL INFARCTION, INFEROPOSTERIOR WALL, NOS
4104	41040	ACUTE MYOCARDIAL INFARCTION, OF OTH INFERIOR WALL, NOS

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
4105	41050	ACUTE MYOCARDIAL INFARCTION, OF OTHER LATERAL WALL, NOS
4106	41060	ACUTE MYOCARDIAL INFARCTION, TRUE POSTERIOR WALL INFARCTN
4107	41070	SUBENDOCARDIAL INFARCTION, EPISODE OF CARE UNSPECIFIED
4108	41080	ACUTE MYOCARDIAL INFARCTION, OTH SPECIFIED SITES, NOS
4109	41090	ACUTE MYOCARDIAL INFARCTION, UNSPEC SITE, EPISODE NOS
4118	41189	OTH ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE
4141	41411	ANEURYSM OF CORONARY VESSELS
4209	42091	ACUTE IDIOPATHIC PERICARDITIS
4229	42291	IDIOPATHIC MYOCARDITIS
4249	42490	ENDOCARDITIS, VALVE UNSPECIFIED, UNSPECIFIED CAUSE
4261	42610	ATRIOVENTRICULAR BLOCK, UNSPECIFIED
4265	42653	OTHER BILATERAL BUNDLE BRANCH BLOCK
4268	42689	OTHER SPECIFIED CONDUCTION DISORDERS
4273	42731	ATRIAL FIBRILLATION
4274	42742	VENTRICULAR FLUTTER
4276	42769	OTHER PREMATURE BEATS
4278	42789	OTHER SPECIFIED CARDIAC DYSRHYTHMIAS
4298	42989	OTHER ILL-DEFINED HEART DISEASES
4428	44289	ANEURYSM OF OTHER SPECIFIED SITE
4438	44389	OTHER PERIPHERAL VASCULAR DISEASE
4442	44422	ARTERIAL EMBOLISM AND THROMBOSIS OF LOWER EXTREMITY
4448	44481	EMBOLISM AND THROMBOSIS OF ILIAC ARTERY
4511	45119	PHLEBITIS AND THROMBOPHLEBITIS OF OTHER DEEP VESSELS OF
4518	45189	PHLEBITIS AND THROMBOPHLEBITIS OF OTHER SITES
4562	45621	ESOPHAGEAL VARICES IN DISEASES CLASSIFIED ELSEWHERE,
4598	45981	VENOUS (PERIPHERAL) INSUFFICIENCY, UNSPECIFIED
4641	46410	ACUTE TRACHEITIS WITHOUT MENTION OF OBSTRUCTION
4642	46420	ACUTE LARYNGOTRACHEITIS WITHOUT MENTION OF OBSTRUCTION
4643	46430	ACUTE EPIGLOTTITIS WITHOUT MENTION OF OBSTRUCTION
4741	47411	HYPERTROPHY OF TONSILS ALONE
4782	47829	OTHER DISEASES OF PHARYNX OR NASOPHARYNX
4783	47830	UNSPECIFIED PARALYSIS OF VOCAL CORDS
4787	47870	UNSPECIFIED DISEASE OF LARYNX
4930	49300	EXTRINSIC ASTHMA WITHOUT MENTION OF STATUS ASTHMATICUS
4931	49310	INTRINSIC ASTHMA WITHOUT MENTION OF STATUS ASTHMATICUS
4939	49390	ASTHMA, UNSPECIFIED TYPE, WITHOUT MENTION OF STATUS AST
5188	51889	OTHER DISEASES OF LUNG, NOT ELSEWHERE CLASSIFIED
5268	52681	EXOSTOSIS OF JAW
5310	53100	ACUTE GASTRIC ULCER WITH HEMORRHAGE,
5311	53110	ACUTE GASTRIC ULCER WITH PERFORATION,
5312	53120	ACUTE GASTRIC ULCER WITH HEMORRHAGE AND PERFORATION,
5313	53130	ACUTE GASTRIC ULCER WITHOUT MENTION OF HEMORRHAGE OR
5314	53140	CHRONIC OR UNSPECIFIED GASTRIC ULCER WITH HEMORRHAGE,
5315	53150	CHRONIC OR UNSPECIFIED GASTRIC ULCER WITH PERFORATION,
5316	53160	CHRONIC OR UNSPECIFIED GASTRIC ULCER WITH HEMORRHAGE AN
5317	53170	CHRONIC GASTRIC ULCER WITHOUT MENTION OF HEMORRHAGE OR
5319	53190	GASTRIC ULCER, UNSPECIFIED AS ACUTE OR CHRONIC, WITHOUT

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5320	53200	ACUTE DUODENAL ULCER WITH HEMORRHAGE, WITHOUT MENTION O
5321	53210	ACUTE DUODENAL ULCER WITH PERFORATION, WITHOUT MENTION
5322	53220	ACUTE DUODENAL ULCER WITH HEMORRHAGE AND PERFORATION,
5323	53230	ACUTE DUODENAL ULCER WITHOUT MENTION OF HEMORRHAGE OR
5324	53240	CHRONIC OR UNSPECIFIED DUODENAL ULCER WITH HEMORRHAGE,
5325	53250	CHRONIC OR UNSPECIFIED DUODENAL ULCER WITH PERFORATION,
5326	53260	CHRONIC OR UNSPECIFIED DUODENAL ULCER WITH HEMORRHAGE A
5327	53270	CHRONIC DUODENAL ULCER WITHOUT MENTION OF HEMORRHAGE OR
5329	53290	DUODENAL ULCER, UNSPECIFIED AS ACUTE OR CHRONIC, WITHOU
5330	53300	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITH HEMORRHAGE,
5331	53310	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITH PERFORATION
5332	53320	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITH HEMORRHAGE
5333	53330	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITHOUT MENTION
5334	53340	CHRONIC OR UNSPECIFIED PEPTIC ULCER OF UNSPECIFIED SITE
5335	53350	CHRONIC OR UNSPECIFIED PEPTIC ULCER OF UNSPECIFIED SITE
5336	53360	CHRONIC OR UNSPECIFIED PEPTIC ULCER OF UNSPECIFIED SITE
5337	53370	CHRONIC PEPTIC ULCER OF UNSPECIFIED SITE WITHOUT MENTIO
5339	53390	PEPTIC ULCER OF UNSPECIFIED SITE, UNSPECIFIED AS ACUTE
5340	53400	ACUTE GASTROJEJUNAL ULCER WITH HEMORRHAGE,
5341	53410	ACUTE GASTROJEJUNAL ULCER WITH PERFORATION,
5342	53420	ACUTE GASTROJEJUNAL ULCER WITH HEMORRHAGE AND PERFORATI
5343	53430	ACUTE GASTROJEJUNAL ULCER WITHOUT MENTION OF HEMORRHAGE
5344	53440	CHRONIC OR UNSPECIFIED GASTROJEJUNAL ULCER WITH HEMORRH
5345	53450	CHRONIC OR UNSPECIFIED GASTROJEJUNAL ULCER WITH PERFORA
5346	53460	CHRONIC OR UNSPECIFIED GASTROJEJUNAL ULCER WITH HEMORRH
5347	53470	CHRONIC GASTROJEJUNAL ULCER WITHOUT MENTION OF HEMORRHA
5349	53490	GASTROJEJUNAL ULCER, UNSPECIFIED AS ACUTE OR CHRONIC,
5378	53781	PYLOROSPASM
5500	55000	UNILATERAL OR UNSPECIFIED INGUINAL HERNIA, WITH GANGREN
5501	55010	UNILATERAL OR UNSPECIFIED INGUINAL HERNIA, WITH OBSTRUC
5509	55090	UNILATERAL OR UNSPECIFIED INGUINAL HERNIA, WITHOUT MENT
5510	55100	UNILATERAL OR UNSPECIFIED FEMORAL HERNIA WITH GANGRENE
5512	55120	UNSPECIFIED VENTRAL HERNIA WITH GANGRENE
5520	55200	UNILATERAL OR UNSPECIFIED FEMORAL HERNIA WITH OBSTRUCTI
5522	55220	UNSPECIFIED VENTRAL HERNIA WITH OBSTRUCTION
5530	55300	UNILATERAL OR UNSPECIFIED FEMORAL HERNIA WITHOUT MENTIO
5532	55321	INCISIONAL HERNIA WITHOUT MENTION OF OBSTRUCTION OR GAN
5603	56039	OTHER IMPACTION OF INTESTINE
5608	56081	INTESTINAL OR PERITONEAL ADHESIONS WITH OBSTRUCTION
5620	56200	DIVERTICULOSIS OF SMALL INTESTINE
5621	56211	DIVERTICULITIS OF COLON
5688	56889	OTHER SPECIFIED DISORDERS OF PERITONEUM
5694	56949	OTHER SPECIFIED DISORDERS OF RECTUM AND ANUS
5698	56982	ULCERATION OF INTESTINE
5714	57140	CHRONIC HEPATITIS, UNSPECIFIED
5740	57400	CALCULUS OF GALLBLADDER WITH ACUTE CHOLECYSTITIS,
5741	57410	CALCULUS OF GALLBLADDER WITH OTHER CHOLECYSTITIS,

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5742	57420	CALCULUS OF GALLBLADDER WITHOUT MENTION OF CHOLECYSTITI
5743	57430	CALCULUS OF BILE DUCT WITH ACUTE CHOLECYSTITIS
5744	57440	CALCULUS OF BILE DUCT WITH OTHER CHOLECYSTITIS,
5745	57450	CALCULUS OF BILE DUCT WITHOUT MENTION OF CHOLECYSTITIS,
5808	58089	ACUTE GLOMERULONEPHRITIS WITH OTHER SPECIFIED PATHOLOGI
5818	58189	NEPHROTIC SYNDROME WITH OTHER SPECIFIED PATHOLOGICAL LE
5828	58289	CHRONIC GLOMERULONEPHRITIS WITH OTHER SPECIFIED PATHOLO
5838	58389	NEPHRITIS AND NEPHROPATHY, NOT SPECIFIED AS ACUTE OR CH
5900	59000	CHRONIC PYELONEPHRITIS WITHOUT LESION OF RENAL MEDULLAR
5901	59010	ACUTE PYELONEPHRITIS WITHOUT LESION OF RENAL MEDULLARY
5908	59080	PYELONEPHRITIS, UNSPECIFIED
5938	59389	OTHER SPECIFIED DISORDERS OF KIDNEY AND URETER
5958	59589	OTHER SPECIFIED TYPES OF CYSTITIS
5978	59780	URETHRITIS, UNSPECIFIED
5980	59800	URETHRAL STRUCTURE DUE TO UNSPECIFIED INFECTION
6049	60490	ORCHITIS AND EPIDIDYMITIS, UNSPECIFIED
6078	60784	IMPOTENCE OF ORGANIC ORIGIN
6088	60889	OTHER SPECIFIED DISORDERS OF MALE GENITAL ORGANS
6117	61172	LUMP OR MASS IN BREAST
6161	61610	VAGINITIS AND VULVOVAGINITIS, UNSPECIFIED
6165	61650	ULCERATION OF VULVA, UNSPECIFIED
6340	63400	SPONTANEOUS ABORTION, UNSPECIFIED, COMPLICATED BY GENIT
6341	63410	SPONTANEOUS ABORTION, UNSPECIFIED, COMPLICATED BY DELAY
6342	63420	SPONTANEOUS ABORTION, UNSPECIFIED, COMPLICATED BY DAMAG
6343	63430	SPONTANEOUS ABORTION, UNSPECIFIED, COMPLICATED BY RENAL
6344	63440	SPONTANEOUS ABORTION, UNSPECIFIED, COMPLICATED BY METAB
6345	63450	SPONTANEOUS ABORTION, UNSPECIFIED, COMPLICATED BY SHOCK
6346	63460	SPONTANEOUS ABORTION, UNSPECIFIED, COMPLICATED BY EMBOL
6347	63470	SPONTANEOUS ABORTION, UNSPECIFIED, WITH OTHER SPECIFIED
6348	63480	SPONTANEOUS ABORTION, UNSPECIFIED, WITH UNSPECIFIED
6349	63490	SPONTANEOUS ABORTION, UNSPECIFIED, WITHOUT MENTION OF
6350	63500	LEGALLY INDUCED ABORTION, UNSPECIFIED, COMPLICATED BY G
6351	63510	LEGALLY INDUCED ABORTION, UNSPECIFIED, COMPLICATED BY D
6352	63520	LEGALLY INDUCED ABORTION, UNSPECIFIED, COMPLICATED BY D
6353	63530	LEGALLY INDUCED ABORTION, UNSPECIFIED, COMPLICATED BY R
6354	63540	LEGALLY INDUCED ABORTION, UNSPECIFIED, COMPLICATED BY
6355	63550	LEGALLY INDUCED ABORTION, UNSPECIFIED, COMPLICATED BY S
6356	63560	LEGALLY INDUCED ABORTION, UNSPECIFIED, COMPLICATED BY E
6357	63570	LEGALLY INDUCED ABORTION, UNSPECIFIED, WITH OTHER SPECI
6358	63580	LEGALLY INDUCED ABORTION, UNSPECIFIED, WITH UNSPECIFIED
6359	63590	LEGALLY INDUCED ABORTION, UNSPECIFIED, WITHOUT MENTION
6360	63600	ILLEGAL ABORTION, UNSPECIFIED, COMPLICATED BY GENITAL T
6361	63610	ILLEGAL ABORTION, UNSPECIFIED, COMPLICATED BY DELAYED O
6362	63620	ILLEGAL ABORTION, UNSPECIFIED, COMPLICATED BY DAMAGE TO
6363	63630	ILLEGAL ABORTION, UNSPECIFIED, COMPLICATED BY RENAL FAI
6364	63640	ILLEGAL ABORTION, UNSPECIFIED, COMPLICATED BY METABOLIC
6365	63650	ILLEGAL ABORTION, UNSPECIFIED, COMPLICATED BY SHOCK

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6366	63660	ILLEGAL ABORTION, UNSPECIFIED, COMPLICATED BY EMBOLISM
6367	63670	ILLEGAL ABORTION, UNSPECIFIED, WITH OTHER SPECIFIED
6368	63680	ILLEGAL ABORTION, UNSPECIFIED, WITH UNSPECIFIED COMPLIC
6369	63690	ILLEGAL ABORTION, UNSPECIFIED, WITHOUT MENTION OF COMPL
6370	63700	UNSPECIFIED TYPE OF ABORTION, UNSPECIFIED, COMPLICATED
6371	63710	UNSPECIFIED TYPE OF ABORTION, UNSPECIFIED, COMPLICATED
6372	63720	UNSPECIFIED TYPE OF ABORTION, UNSPECIFIED, COMPLICATED
6373	63730	UNSPECIFIED TYPE OF ABORTION, UNSPECIFIED, COMPLICATED
6374	63740	UNSPECIFIED TYPE OF ABORTION, UNSPECIFIED, COMPLICATED
6375	63750	UNSPECIFIED TYPE OF ABORTION, UNSPECIFIED, COMPLICATED
6376	63760	UNSPECIFIED TYPE OF ABORTION, UNSPECIFIED, COMPLICATED
6377	63770	UNSPECIFIED TYPE OF ABORTION, UNSPECIFIED, WITH OTHER S
6378	63780	UNSPECIFIED TYPE OF ABORTION, UNSPECIFIED, WITH UNSPECI
6379	63791	UNSPECIFIED ABORTION, INCOMPLETE, WITHOUT MENTION OF
6400	64000	THREATENED ABORTION, UNSPECIFIED AS TO EPISODE OF CARE
6408	64080	OTHER SPECIFIED HEMORRHAGE IN EARLY PREGNANCY, UNSPECIF
6409	64093	UNSPECIFIED HEMORRHAGE IN EARLY PREGNANCY, ANTEPARTUM
6410	64103	PLACENTA PREVIA WITHOUT HEMORRHAGE, ANTEPARTUM
6411	64110	HEMORRHAGE FROM PLACENTA PREVIA, UNSPECIFIED AS TO EPIS
6412	64123	PREMATURE SEPARATION OF PLACENTA, ANTEPARTUM
6413	64133	ANTEPARTUM HEMORRHAGE ASSOCIATED WITH COAGULATION DEFEC
6418	64183	OTHER ANTEPARTUM HEMORRHAGE
6419	64193	UNSPECIFIED ANTEPARTUM HEMORRHAGE
6420	64203	ANTEPARTUM BENIGN ESSENTIAL HYPERTENSION
6421	64213	HYPERTENSION SECONDARY TO RENAL DISEASE, ANTEPARTUM
6422	64223	OTHER PRE-EXISTING HYPERTENSION, ANTEPARTUM
6423	64233	ANTEPARTUM TRANSIENT HYPERTENSION
6424	64243	MILD OR UNSPECIFIED PRE-ECLAMPSIA, ANTEPARTUM
6425	64253	SEVERE PRE-ECLAMPSIA, ANTEPARTUM
6426	64264	ECLAMPSIA, POSTPARTUM
6427	64273	PRE-ECLAMPSIA OR ECLAMPSIA SUPERIMPOSED ON PRE-EXISTING
6429	64293	UNSPECIFIED ANTEPARTUM HYPERTENSION
6430	64303	MILD HYPEREMESIS GRAVIDARUM, ANTEPARTUM
6431	64313	HYPEREMESIS GRAVIDARUM WITH METABOLIC DISTURBANCE, ANTE
6432	64323	LATE VOMITING OF PREGNANCY, ANTEPARTUM
6438	64383	OTHER VOMITING COMPLICATING PREGNANCY, ANTEPARTUM
6439	64393	UNSPECIFIED VOMITING OF PREGNANCY, ANTEPARTUM
6440	64403	THREATENED PREMATURE LABOR, ANTEPARTUM
6441	64413	OTHER THREATENED LABOR, ANTEPARTUM
6442	64420	EARLY ONSET OF DELIVERY, UNSPECIFIED AS TO EPISODE OF C
6450	64503	PROLONGED PREGNANCY, ANTEPARTUM
6460	64603	PAPYRACEOUS FETUS, ANTEPARTUM
6461	64613	ANTEPARTUM EDEMA OR EXCESSIVE WEIGHT GAIN
6462	64623	UNSPECIFIED ANTEPARTUM RENAL DISEASE
6463	64633	HABITUAL ABORTER, ANTEPARTUM CONDITION OR COMPLICATION
6464	64643	ANTEPARTUM PERIPHERAL NEURITIS
6465	64653	ANTEPARTUM ASYMPTOMATIC BACTERIURIA

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
6466	64663	ANTEPARTUM INFECTIONS OF GENITOURINARY TRACT
6467	64673	ANTEPARTUM LIVER DISORDERS
6468	64683	OTHER SPECIFIED ANTEPARTUM COMPLICATIONS
6469	64693	UNSPECIFIED ANTEPARTUM COMPLICATION
6470	64703	ANTEPARTUM SYPHILIS
6471	64713	ANTEPARTUM GONORRHEA
6472	64723	OTHER ANTEPARTUM VENEREAL DISEASES
6473	64733	ANTEPARTUM TUBERCULOSIS
6474	64743	ANTEPARTUM MALARIA
6475	64753	ANTEPARTUM RUBELLA
6476	64763	OTHER ANTEPARTUM VIRAL DISEASES
6478	64783	OTHER SPECIFIED INFECTIOUS AND PARASITIC DISEASES OF MO
6479	64794	UNSPECIFIED INFECTION OR INFESTATION OF MOTHER, POSTPAR
6480	64803	ANTEPARTUM DIABETES MELLITUS
6481	64813	ANTEPARTUM THYROID DYSFUNCTION
6482	64823	ANTEPARTUM ANEMIA
6483	64833	ANTEPARTUM DRUG DEPENDENCE
6484	64844	POSTPARTUM MENTAL DISORDERS OF MOTHER
6485	64853	CONGENITAL CARDIOVASCULAR DISORDERS OF MOTHER, ANTEPART
6486	64863	OTHER CARDIOVASCULAR DISEASES OF MOTHER, ANTEPARTUM
6487	64873	BONE AND JOINT DISORDERS OF BACK, PELVIS, AND LOWER LIM
6488	64883	ABNORMAL GLUCOSE TOLERANCE OF MOTHER, ANTEPARTUM
6489	64893	OTHER CURRENT CONDITIONS CLASSIFIABLE ELSEWHERE OF MOTH
6510	65103	TWIN PREGNANCY, ANTEPARTUM CONDITION OR COMPLICATION
6511	65111	TRIPLET PREGNANCY, DELIVERED
6512	65121	QUADRUPLET PREGNANCY, DELIVERED
6518	65181	OTHER SPECIFIED MULTIPLE GESTATION, DELIVERED
6519	65193	UNSPECIFIED MULTIPLE GESTATION, ANTEPARTUM CONDITION OR
6520	65201	UNSTABLE LIE, DELIVERED
6521	65211	BREECH OR OTHER MALPRESENTATION SUCCESSFULLY CONVERTED
6522	65223	BREECH PRESENTATION WITHOUT MENTION OF VERSION, ANTEPAR
6523	65233	TRANSVERSE OR OBLIQUE PRESENTATION, ANTEPARTUM
6524	65241	FACE OR BROW PRESENTATION, DELIVERED
6525	65251	HIGH HEAD AT TERM, DELIVERED
6526	65261	MULTIPLE GESTATION WITH MALPRESENTATION OF ONE FETUS
6527	65271	PROLAPSED ARM OF FETUS, DELIVERED
6528	65281	OTHER SPECIFIED MALPOSITION OR MALPRESENTATION, DELIVER
6529	65291	UNSPECIFIED MALPOSITION OR MALPRESENTATION, DELIVERED
6530	65301	MAJOR ABNORMALITY OF BONY PELVIS, NOT FURTHER SPECIFIED
6531	65311	GENERALLY CONTRACTED PELVIS, DELIVERED
6532	65321	INLET CONTRACTION OF PELVIS, DELIVERED
6533	65331	OUTLET CONTRACTION OF PELVIS, DELIVERED
6534	65343	FETOPELVIC DISPROPORTION, ANTEPARTUM
6535	65351	UNUSUALLY LARGE FETUS CAUSING DISPROPORTION, DELIVERED
6536	65360	HYDROCEPHALIC FETUS CAUSING DISPROPORTION, UNSPECIFIED
6537	65371	OTHER FETAL ABNORMALITY CAUSING DISPROPORTION, DELIVERE
6538	65381	DISPROPORTION OF OTHER ORIGIN, DELIVERED

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6539	65391	UNSPECIFIED DISPROPORTION, DELIVERED
6540	65401	CONGENITAL ABNORMALITIES OF UTERUS, WITH DELIVERY
6541	65413	TUMORS OF BODY OF UTERUS, ANTEPARTUM CONDITION OR COMPL
6542	65423	UTERINE SCAR FROM PREVIOUS SURGERY, ANTEPARTUM CONDITIO
6543	65434	RETROVERTED AND INCARCERATED GRAVID UTERUS, POSTPARTUM
6544	65443	OTHER ABNORMALITIES IN SHAPE OR POSITION OF GRAVID UTER
6545	65453	CERVICAL INCOMPETENCE, ANTEPARTUM CONDITION OR COMPLICA
6546	65463	OTHER CONGENITAL OR ACQUIRED ABNORMALITY OF CERVIX, ANT
6547	65471	CONGENITAL OR ACQUIRED ABNORMALITY OF VAGINA, WITH DELI
6548	65481	CONGENITAL OR ACQUIRED ABNORMALITY OF VULVA, WITH DELIV
6549	65491	UNSPECIFIED ABNORMALITY OF ORGANS AND SOFT TISSUES OF P
6550	65501	CENTRAL NERVOUS SYSTEM MALFORMATION IN FETUS, WITH DELI
6551	65513	CHROMOSOMAL ABNORMALITY IN FETUS, AFFECTING MANAGEMENT
6552	65521	HEREDITARY DISEASE IN FAMILY POSSIBLY AFFECTING FETUS,
6553	65531	SUSPECTED DAMAGE TO FETUS FROM VIRAL DISEASE IN THE MOT
6554	65541	SUSPECTED DAMAGE TO FETUS FROM OTHER DISEASE IN THE MOT
6555	65551	SUSPECTED DAMAGE TO FETUS FROM DRUGS, AFFECTING MANAGEM
6556	65561	SUSPECTED DAMAGE TO FETUS FROM RADIATION, AFFECTING MAN
6558	65581	OTHER KNOWN OR SUSPECTED FETAL ABNORMALITY, NOT ELSEWHE
6559	65591	UNSPECIFIED SUSPECTED FETAL ABNORMALITY, AFFECTING MANA
6560	65601	FETAL-MATERNAL HEMORRHAGE, WITH DELIVERY
6561	65613	RHESUS ISOIMMUNIZATION, AFFECTING MANAGEMENT OF MOTHER,
6562	65621	ISOIMMUNIZATION FROM OTHER AND UNSPECIFIED BLOOD-GROUP
6563	65633	FETAL DISTRESS, AFFECTING MANAGEMENT OF MOTHER, ANTEPAR
6564	65643	INTRAUTERINE DEATH, AFFECTING MANAGEMENT OF MOTHER, ANT
6565	65653	POOR FETAL GROWTH, AFFECTING MANAGEMENT OF MOTHER, ANTE
6566	65663	EXCESSIVE FETAL GROWTH, AFFECTING MANAGEMENT OF MOTHER,
6567	65673	OTHER PLACENTAL CONDITIONS, AFFECTING MANAGEMENT OF MOT
6568	65681	OTHER SPECIFIED FETAL AND PLACENTAL PROBLEMS, AFFECTING
6569	65691	UNSPECIFIED FETAL AND PLACENTAL PROBLEM, AFFECTING MANA
6570	65703	POLYHYDRAMNIOS, ANTEPARTUM COMPLICATION
6580	65801	OLIGOHYDRAMNIOS, DELIVERED
6581	65813	PREMATURE RUPTURE OF MEMBRANES, ANTEPARTUM
6582	65823	DELAYED DELIVERY AFTER SPONTANEOUS OR UNSPECIFIED RUPTU
6583	65831	DELAYED DELIVERY AFTER ARTIFICIAL RUPTURE OF MEMBRANES,
6584	65841	INFECTION OF AMNIOTIC CAVITY, DELIVERED
6588	65881	OTHER PROBLEMS ASSOCIATED WITH AMNIOTIC CAVITY AND MEMB
6589	65891	UNSPECIFIED PROBLEM ASSOCIATED WITH AMNIOTIC CAVITY AND
6590	65901	FAILED MECHANICAL INDUCTION OF LABOR, DELIVERED
6591	65911	FAILED MEDICAL OR UNSPECIFIED INDUCTION OF LABOR, DELIV
6592	65921	UNSPECIFIED TYPE MATERNAL PYREXIA DURING LABOR, DELIVER
6593	65931	GENERALIZED INFECTION DURING LABOR, DELIVERED
6594	65941	GRAND MULTIPARITY, WITH CURRENT PREGNANCY, DELIVERED
6595	65953	ELDERLY PRIMIGRAVIDA, ANTEPARTUM
6598	65981	OTHER SPECIFIED INDICATIONS FOR CARE OR INTERVENTION RE
6599	65991	UNSPECIFIED INDICATION FOR CARE OR INTERVENTION RELATED
6600	66001	OBSTRUCTION CAUSED BY MALPOSITION OF FETUS AT ONSET OF

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
6601	66011	OBSTRUCTION BY BONY PELVIS DURING LABOR, WITH DELIVERY
6602	66021	OBSTRUCTION BY ABNORMAL PELVIC SOFT TISSUES DURING LABO
6603	66031	DEEP TRANSVERSE ARREST AND PERSISTENT OCCIPITOPOSTERIOR
6604	66041	SHOULDER (GIRDLE) DYSTOCIA, WITH DELIVERY
6605	66051	LOCKED TWINS, WITH DELIVERY
6606	66061	UNSPECIFIED FAILED TRIAL OF LABOR, WITH DELIVERY
6607	66071	UNSPECIFIED FAILED FORCEPS OR VACUUM EXTRACTOR, WITH DE
6608	66081	OTHER CAUSES OF OBSTRUCTED LABOR, WITH DELIVERY
6609	66091	UNSPECIFIED OBSTRUCTED LABOR, WITH DELIVERY
6610	66101	PRIMARY UTERINE INERTIA, WITH DELIVERY
6611	66111	SECONDARY UTERINE INERTIA, WITH DELIVERY
6612	66123	OTHER AND UNSPECIFIED UTERINE INERTIA, ANTEPARTUM
6613	66133	PRECIPITATE LABOR, ANTEPARTUM
6614	66141	HYPERTONIC, INCOORDINATE, OR PROLONGED UTERINE CONTRACT
6619	66191	UNSPECIFIED ABNORMALITY OF LABOR, WITH DELIVERY
6620	66201	PROLONGED FIRST STAGE OF LABOR, DELIVERED
6621	66211	UNSPECIFIED TYPE PROLONGED LABOR, DELIVERED
6622	66221	PROLONGED SECOND STAGE OF LABOR, DELIVERED
6623	66231	DELAYED DELIVERY OF SECOND TWIN, TRIPLET, ETC., DELIVER
6630	66301	PROLAPSE OF CORD COMPLICATING LABOR AND DELIVERY, DELIV
6631	66311	CORD AROUND NECK, WITH COMPRESSION, COMPLICATING LABOR
6632	66321	OTHER AND UNSPECIFIED CORD ENTANGLEMENT, WITH COMPRESSI
6633	66331	OTHER AND UNSPECIFIED CORD ENTANGLEMENT, WITHOUT MENTIO
6634	66341	SHORT CORD COMPLICATING LABOR AND DELIVERY, DELIVERED
6635	66351	VASA PREVIA COMPLICATING LABOR AND DELIVERY, DELIVERED
6636	66361	VASCULAR LESIONS OF CORD COMPLICATING LABOR AND DELIVER
6638	66381	OTHER UMBILICAL CORD COMPLICATIONS DURING LABOR AND DEL
6639	66391	UNSPECIFIED UMBILICAL CORD COMPLICATION DURING LABOR AN
6640	66401	FIRST-DEGREE PERINEAL LACERATION, WITH DELIVERY
6641	66411	SECOND-DEGREE PERINEAL LACERATION, WITH DELIVERY
6642	66421	THIRD-DEGREE PERINEAL LACERATION, WITH DELIVERY
6643	66431	FOURTH-DEGREE PERINEAL LACERATION, WITH DELIVERY
6644	66441	UNSPECIFIED PERINEAL LACERATION, WITH DELIVERY
6645	66451	VULVAR AND PERINEAL HEMATOMA, WITH DELIVERY
6648	66481	OTHER SPECIFIED TRAUMA TO PERINEUM AND VULVA, WITH DELI
6649	66491	UNSPECIFIED TRAUMA TO PERINEUM AND VULVA, WITH DELIVERY
6650	66501	RUPTURE OF UTERUS BEFORE ONSET OF LABOR, WITH DELIVERY
6651	66511	RUPTURE OF UTERUS, WITH DELIVERY
6652	66521	INVERSION OF UTERUS, WITH DELIVERY
6653	66531	LACERATION OF CERVIX, WITH DELIVERY
6654	66541	HIGH VAGINAL LACERATION, WITH DELIVERY
6655	66551	OTHER INJURY TO PELVIC ORGANS, WITH DELIVERY
6656	66561	DAMAGE TO PELVIC JOINTS AND LIGAMENTS, WITH DELIVERY
6657	66571	PELVIC HEMATOMA, WITH DELIVERY
6658	66581	OTHER SPECIFIED OBSTETRICAL TRAUMA, WITH DELIVERY
6659	66591	UNSPECIFIED OBSTETRICAL TRAUMA, WITH DELIVERY
6660	66604	THIRD-STAGE POSTPARTUM HEMORRHAGE, WITH DELIVERY,

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6661	66614	OTHER IMMEDIATE POSTPARTUM HEMORRHAGE, WITH DELIVERY,
6662	66620	DELAYED AND SECONDARY POSTPARTUM HEMORRHAGE, UNSPECIFIE
6663	66631	POSTPARTUM COAGULATION DEFECTS, WITH DELIVERY, WITH OR
6670	66704	RETAINED PLACENTA WITHOUT HEMORRHAGE, WITH DELIVERY,
6671	66714	RETAINED PORTIONS OF PLACENTA OR MEMBRANES, WITHOUT
6680	66801	PULMONARY COMPLICATIONS OF ANESTHESIA OR OTHER SEDATION
6681	66811	CARDIAC COMPLICATIONS OF ANESTHESIA OR OTHER SEDATION I
6682	66821	CENTRAL NERVOUS SYSTEM COMPLICATIONS OF ANESTHESIA OR O
6688	66881	OTHER COMPLICATIONS OF ANESTHESIA OR OTHER SEDATION IN
6689	66891	UNSPECIFIED COMPLICATION OF ANESTHESIA OR OTHER SEDATIO
6690	66901	MATERNAL DISTRESS, WITH DELIVERY, WITH OR WITHOUT MENTI
6691	66911	OBSTETRIC SHOCK, WITH DELIVERY, WITH OR WITHOUT MENTION
6692	66923	MATERNAL HYPOTENSION SYNDROME, ANTEPARTUM
6693	66931	ACUTE RENAL FAILURE WITH DELIVERY, WITH OR WITHOUT MEN
6694	66941	OTHER COMPLICATIONS OF OBSTETRICAL SURGERY AND PROCEDUR
6695	66951	FORCEPS OR VACUUM EXTRACTOR DELIVERY WITHOUT MENTION OF
6696	66961	BREECH EXTRACTION, WITHOUT MENTION OF INDICATION,
6697	66971	CESAREAN DELIVERY, WITHOUT MENTION OF INDICATION,
6698	66981	OTHER COMPLICATIONS OF LABOR AND DELIVERY, DELIVERED,
6699	66991	UNSPECIFIED COMPLICATION OF LABOR AND DELIVERY, WITH DE
6700	67004	MAJOR PUERPERAL INFECTION, POSTPARTUM
6710	67103	ANTEPARTUM VARICOSE VEINS OF LEGS
6711	67114	POSTPARTUM VARICOSE VEINS OF VULVA AND PERINEUM
6712	67124	POSTPARTUM SUPERFICIAL THROMBOPHLEBITIS
6713	67130	DEEP PHLEBOTHROMBOSIS, ANTEPARTUM, POSTPARTUM CONDITIO
6714	67144	DEEP PHLEBOTHROMBOSIS, POSTPARTUM
6715	67154	OTHER POSTPARTUM PHLEBITIS AND THROMBOSIS
6718	67184	OTHER POSTPARTUM VENOUS COMPLICATIONS
6719	67194	UNSPECIFIED POSTPARTUM VENOUS COMPLICATION
6720	67204	PUERPERAL PYREXIA OF UNKNOWN ORIGIN, POSTPARTUM
6730	67304	OBSTETRICAL AIR EMBOLISM, POSTPARTUM CONDITION OR COMPL
6731	67314	AMNIOTIC FLUID EMBOLISM, POSTPARTUM CONDITION OR COMPLI
6732	67324	OBSTETRICAL BLOOD-CLOT EMBOLISM, POSTPARTUM
6733	67334	OBSTETRICAL PYEMIC AND SEPTIC EMBOLISM, POSTPARTUM
6738	67384	OTHER OBSTETRICAL PULMONARY EMBOLISM, POSTPARTUM
6740	67404	POSTPARTUM CEREBROVASCULAR DISORDERS
6741	67414	DISRUPTION OF CESAREAN WOUND, POSTPARTUM
6742	67422	DISRUPTION OF PERINEAL WOUND, WITH DELIVERY, WITH MENTI
6743	67434	OTHER COMPLICATIONS OF OBSTETRICAL SURGICAL WOUNDS,
6744	67444	PLACENTAL POLYP, POSTPARTUM
6748	67484	OTHER COMPLICATIONS OF PUERPERIUM
6749	67494	UNSPECIFIED COMPLICATIONS OF PUERPERIUM
6750	67504	POSTPARTUM INFECTIONS OF NIPPLE
6751	67514	POSTPARTUM ABSCESS OF BREAST
6752	67524	POSTPARTUM NONPURULENT MASTITIS
6758	67584	OTHER SPECIFIED POSTPARTUM INFECTIONS OF THE BREAST AND
6759	67594	UNSPECIFIED POSTPARTUM INFECTION OF THE BREAST AND NIPP

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
6760	67604	RETRACTED NIPPLE ASSOCIATED WITH CHILDBIRTH, POSTPARTUM
6761	67614	CRACKED NIPPLE ASSOCIATED WITH CHILDBIRTH, POSTPARTUM C
6762	67624	POSTPARTUM ENGORGEMENT OF BREASTS ASSOCIATED WITH CHILD
6763	67634	OTHER AND UNSPECIFIED DISORDER OF BREAST ASSOCIATED WIT
6764	67644	FAILURE OF LACTATION, POSTPARTUM CONDITION OR COMPLICAT
6765	67654	SUPPRESSED LACTATION, POSTPARTUM CONDITION OR COMPLICAT
6766	67660	GALACTORRHEA ASSOCIATED WITH CHILDBIRTH, UNSPECIFIED AS
6768	67684	OTHER DISORDERS OF LACTATION, POSTPARTUM CONDITION OR
6769	67694	UNSPECIFIED DISORDER OF LACTATION, POSTPARTUM CONDITION
6810	68100	UNSPECIFIED CELLULITIS AND ABSCESS OF FINGER
6811	68110	UNSPECIFIED CELLULITIS AND ABSCESS OF TOE
6927	69279	OTHER DERMATITIS DUE TO SUN
6928	69289	CONTACT DERMATITIS AND OTHER ECZEMA DUE TO OTHER SPECIF
6946	69461	BENIGN MUCOUS MEMBRANE PEMPHIGOID WITH OCULAR INVOLVEME
6958	69589	OTHER SPECIFIED ERYTHEMATOUS CONDITIONS
7040	70400	ALOPECIA, UNSPECIFIED
7058	70581	DYSHIDROSIS
7110	71100	PYOGENIC ARTHRITIS, SITE UNSPECIFIED
7111	71110	ARTHROPATHY, SITE UNSPECIFIED, ASSOCIATED WITH REITER'S
7112	71120	ARTHROPATHY IN BEHCET'S SYNDROME, SITE UNSPECIFIED
7113	71130	POSTDYSENTERIC ARTHROPATHY, SITE UNSPECIFIED
7114	71140	ARTHROPATHY, SITE UNSPECIFIED, ASSOCIATED WITH OTHER
7115	71150	ARTHROPATHY, SITE UNSPECIFIED, ASSOCIATED
7116	71160	ARTHROPATHY, SITE UNSPECIFIED, ASSOCIATED WITH MYCOSES
7117	71170	ARTHROPATHY, SITE UNSPECIFIED, ASSOCIATED WITH HELMINTH
7118	71180	ARTHROPATHY, SITE UNSPECIFIED, ASSOCIATED WITH OTHER
7119	71190	UNSPECIFIED INFECTIVE ARTHRITIS, SITE UNSPECIFIED
7121	71210	CHONDROCALCINOSIS, DUE TO DICALCIUM PHOSPHATE CRYSTALS,
7122	71220	CHONDROCALCINOSIS, DUE TO PYROPHOSPHATE CRYSTALS,
7123	71230	CHONDROCALCINOSIS, CAUSE UNSPECIFIED,
7128	71280	OTHER SPECIFIED CRYSTAL ARTHROPATHIES, SITE UNSPECIFIED
7129	71290	UNSPECIFIED CRYSTAL ARTHROPATHY, SITE UNSPECIFIED
7143	71430	CHRONIC OR UNSPECIFIED POLYARTICULAR JUVENILE RHEUMATOI
7148	71489	OTHER SPECIFIED INFLAMMATORY POLYARTHROPATHIES
7150	71509	OSTEOARTHROSIS, GENERALIZED, INVOLVING MULTIPLE SITES
7151	71510	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING UNSPECIFI
7152	71520	OSTEOARTHROSIS, LOCALIZED, SECONDARY, INVOLVING UNSPECI
7153	71535	OSTEOARTHROSIS, LOCALIZED, NOT SPECIFIED WHETHER
7158	71589	OSTEOARTHROSIS INVOLVING OR WITH MENTION OF MULTIPLE SI
7159	71590	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCA
7160	71600	KASCHIN-BECK DISEASE, SITE UNSPECIFIED
7161	71610	TRAUMATIC ARTHROPATHY, SITE UNSPECIFIED
7162	71620	ALLERGIC ARTHRITIS, SITE UNSPECIFIED
7163	71630	CLIMACTERIC ARTHRITIS, SITE UNSPECIFIED
7164	71640	TRANSIENT ARTHROPATHY, SITE UNSPECIFIED
7165	71659	UNSPECIFIED POLYARTHROPATHY OR POLYARTHRITIS INVOLVING
7166	71666	UNSPECIFIED MONOARTHRITIS INVOLVING LOWER LEG

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7168	71680	OTHER SPECIFIED ARTHROPATHY, NO SITE SPECIFIED
7169	71690	UNSPECIFIED ARTHROPATHY, SITE UNSPECIFIED
7174	71749	OTHER DERANGEMENT OF LATERAL MENISCUS
7178	71789	OTHER INTERNAL DERANGEMENT OF KNEE
7180	71804	ARTICULAR CARTILAGE DISORDER INVOLVING HAND
7181	71812	LOOSE BODY IN UPPER ARM JOINT
7182	71820	PATHOLOGICAL DISLOCATION OF JOINT, SITE UNSPECIFIED
7183	71831	RECURRENT DISLOCATION OF JOINT OF SHOULDER REGION
7184	71844	CONTRACTURE OF HAND JOINT
7185	71850	ANKYLOSIS OF JOINT, SITE UNSPECIFIED
7186	71860	UNSPECIFIED INTRAPELVIC PROTRUSION OF ACETABULUM,
7188	71886	OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED,
7189	71890	UNSPECIFIED DERANGEMENT OF JOINT, SITE UNSPECIFIED
7190	71906	EFFUSION OF LOWER LEG JOINT
7191	71916	HEMARTHROSIS INVOLVING LOWER LEG
7192	71925	VILLONODULAR SYNOVITIS INVOLVING PELVIC REGION AND THIG
7194	71945	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
7195	71958	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, INVOLVING
7196	71966	OTHER SYMPTOMS REFERABLE TO LOWER LEG JOINT
7197	71970	DIFFICULTY IN WALKING INVOLVING JOINT, SITE UNSPECIFIED
7198	71986	OTHER SPECIFIED DISORDERS OF LOWER LEG JOINT
7199	71996	UNSPECIFIED DISORDER OF LOWER LEG JOINT
7208	72089	OTHER INFLAMMATORY SPONDYLOPATHIES
7214	72141	SPONDYLOSIS WITH MYELOPATHY, THORACIC REGION
7219	72190	SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MENTION OF MYEL
7221	72210	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYEL
7223	72230	SCHMORL'S NODES OF UNSPECIFIED REGION
7225	72252	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DI
7227	72271	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY, CERVICAL
7228	72280	POSTLAMINECTOMY SYNDROME OF UNSPECIFIED REGION
7229	72293	OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION
7240	72400	SPINAL STENOSIS OF UNSPECIFIED REGION
7247	72479	OTHER DISORDERS OF COCCYX
7261	72610	DISORDERS OF BURSAE AND TENDONS IN SHOULDER
7263	72632	LATERAL EPICONDYLITIS
7266	72665	PREPATELLAR BURSITIS
7267	72679	OTHER ENTHESOPATHY OF ANKLE AND TARSUS
7269	72690	ENTHESOPATHY OF UNSPECIFIED SITE
7270	72700	SYNOVITIS AND TENOSYNOVITIS, UNSPECIFIED
7274	72743	GANGLION, UNSPECIFIED
7275	72751	SYNOVIAL CYST OF POPLITEAL SPACE
7276	72760	NONTRAUMATIC RUPTURE OF UNSPECIFIED TENDON
,278	72789	OTHER DISORDERS OF SYNOVIUM, TENDON, AND BURSA
7281	72810	CALCIFICATION AND OSSIFICATION, UNSPECIFIED
7287	72871	PLANTAR FASCIAL FIBROMATOSIS
7288	72885	SPASM OF MUSCLE
7293	72931	HYPERTROPHY OF FAT PAD, KNEE

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7298	72982	CRAMP OF LIMB
7300	73000	ACUTE OSTEOMYELITIS, SITE UNSPECIFIED
7301	73010	CHRONIC OSTEOMYELITIS, SITE UNSPECIFIED
7302	73020	UNSPECIFIED OSTEOMYELITIS, SITE UNSPECIFIED
7303	73036	PERIOSTITIS, WITHOUT MENTION OF OSTEOMYELITIS, INVOLVIN
7307	73070	OSTEOPATHY RESULTING FROM POLIOMYELITIS, INVOLVING UNSP
7308	73080	OTHER INFECTIONS INVOLVING BONE IN DISEASES CLASSIFIED
7309	73090	UNSPECIFIED INFECTION OF BONE, SITE UNSPECIFIED
7330	73300	OSTEOPOROSIS, UNSPECIFIED
7332	73320	CYST OF BONE (LOCALIZED), UNSPECIFIED
7334	73342	ASEPTIC NECROSIS OF HEAD AND NECK OF FEMUR
7338	73382	NONUNION OF FRACTURE
7339	73399	OTHER DISORDERS OF BONE AND CARTILAGE
7360	73600	UNSPECIFIED DEFORMITY OF FOREARM, EXCLUDING FINGERS
7362	73629	OTHER ACQUIRED DEFORMITIES OF FINGER
7363	73630	UNSPECIFIED ACQUIRED DEFORMITY OF HIP
7364	73642	GENU VARUM (ACQUIRED)
7367	73673	CAVUS DEFORMITY OF FOOT, ACQUIRED
7368	73689	OTHER ACQUIRED DEFORMITY OF OTHER PARTS OF LIMB
7371	73710	KYPHOSIS (ACQUIRED) (POSTURAL)
7372	73720	LORDOSIS (ACQUIRED) (POSTURAL)
7373	73730	SCOLIOSIS (AND KYPHOSCOLIOSIS), IDIOPATHIC
7374	73740	UNSPECIFIED CURVATURE OF SPINE ASSOCIATED WITH OTHER CO
7410	74100	SPINA BIFIDA, UNSPECIFIED REGION, WITH HYDROCEPHALUS
7419	74190	SPINA BIFIDA, UNSPECIFIED REGION, WITHOUT MENTION OF
7425	74259	OTHER SPECIFIED CONGENITAL ANOMALIES OF SPINAL CORD
7430	74300	CLINICAL ANOPHTHALMOS, UNSPECIFIED
7431	74310	MICROPHTHALMOS, UNSPECIFIED
7432	74320	BUPHTHALMOS, UNSPECIFIED
7433	74333	CONGENITAL NUCLEAR CATARACT
7434	74343	OTHER CONGENITAL CORNEAL OPACITIES
7435	74359	OTHER CONGENITAL ANOMALIES OF POSTERIOR SEGMENT
7436	74362	CONGENITAL DEFORMITIES OF EYELIDS
7440	74400	UNSPECIFIED CONGENITAL ANOMALY OF EAR WITH IMPAIRMENT O
7442	74429	OTHER CONGENITAL ANOMALIES OF EAR
7444	74442	BRANCHIAL CLEFT CYST
7448	74489	OTHER SPECIFIED CONGENITAL ANOMALIES OF FACE AND NECK
7451	74519	OTHER TRANSPOSITION OF GREAT VESSELS
7456	74561	OSTIUM PRIMUM DEFECT
7460	74609	OTHER CONGENITAL ANOMALIES OF PULMONARY VALVE
7468	74686	CONGENITAL HEART BLOCK
7471	74710	COARCTATION OF AORTA (PREDUCTAL) (POSTDUCTAL)
7472	74720	CONGENITAL ANOMALY OF AORTA, UNSPECIFIED
7474	74740	CONGENITAL ANOMALY OF GREAT VEINS, UNSPECIFIED
7478	74789	OTHER SPECIFIED CONGENITAL ANOMALIES OF CIRCULATORY SYS
7486	74860	CONGENITAL ANOMALY OF LUNG, UNSPECIFIED
7490	74900	CLEFT PALATE, UNSPECIFIED

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7491	74910	CLEFT LIP, UNSPECIFIED
7492	74920	CLEFT PALATE WITH CLEFT LIP, UNSPECIFIED
7501	75012	CONGENITAL ADHESIONS OF TONGUE
7502	75026	OTHER SPECIFIED CONGENITAL ANOMALIES OF MOUTH
7516	75160	UNSPECIFIED CONGENITAL ANOMALY OF GALLBLADDER, BILE DUC
7521	75210	UNSPECIFIED CONGENITAL ANOMALY OF FALLOPIAN TUBES AND B
7524	75249	OTHER CONGENITAL ANOMALIES OF CERVIX, VAGINA, AND EXTER
7543	75430	CONGENITAL DISLOCATION OF HIP, UNILATERAL
7544	75444	CONGENITAL BOWING OF UNSPECIFIED LONG BONES OF LEG
7545	75453	CONGENITAL METATARSUS VARUS
7546	75461	CONGENITAL PES PLANUS
7547	75470	TALIPES, UNSPECIFIED
7548	75489	OTHER SPECIFIED NONTERATOGENIC ANOMALIES
7550	75502	POLYDACTYLY OF TOES
7551	75511	SYNDACTYLY OF FINGERS WITHOUT FUSION OF BONE
7552	75520	UNSPECIFIED REDUCTION DEFORMITY OF UPPER LIMB, CONGENIT
7553	75530	UNSPECIFIED REDUCTION DEFORMITY OF LOWER LIMB, CONGENIT
7555	75552	CONGENITAL ELEVATION OF SCAPULA
7556	75563	OTHER CONGENITAL DEFORMITY OF HIP (JOINT)
7561	75612	SPONDYLOLISTHESIS, CONGENITAL
7565	75659	OTHER CONGENITAL OSTEODYSTROPHIES
7568	75683	EHLERS-DANLOS SYNDROME
7573	75739	OTHER SPECIFIED CONGENITAL ANOMALIES OF SKIN
7598	75989	OTHER SPECIFIED ANOMALIES
7607	76079	OTHER NOXIOUS INFLUENCES AFFECTING FETUS OR NEWBORN VIA
7640	76400	"LIGHT-FOR-DATES" WO MENT FETAL MALNUTRITION,UNSPEC WGT
7641	76410	"LIGHT-FOR-DATES" W SIGNS FETAL MALNUTRITION,UNSPEC WGT
7642	76420	FETAL MALNUTRITION WO MENT "LIGHT-FOR-DATES",UNSP WGT
7650	76500	EXTREME IMMATURITY, UNSPECIFIED WEIGHT
7651	76510	OTHER PRETERM INFANTS, UNSPECIFIED WEIGHT
7743	77430	NEONATAL JAUNDICE DUE TO DELAYED CONJUGATION, CAUSE UNS
7805	78052	OTHER INSOMNIA
7826	78261	PALLOR
7844	78449	OTHER VOICE DISTURBANCE
7846	78469	OTHER SYMBOLIC DYSFUNCTION
7855	78559	OTHER SHOCK WITHOUT MENTION OF TRAUMA
7860	78609	OTHER DYSPNEA AND RESPIRATORY ABNORMALITY
7865	78650	UNSPECIFIED CHEST PAIN
7940	79409	OTHER NONSPECIFIC ABNORMAL RESULTS OF FUNCTION STUDY OF
7941	79410	NONSPECIFIC ABNORMAL RESPONSE TO UNSPECIFIED NERVE STIM
7943	79431	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (ECG) (EKG)
8000	80000	CLOSED FRACTURE OF VAULT OF SKULL WITHOUT MENTION OF
8001	80010	CLOSED FRACTURE OF VAULT OF SKULL WITH CEREBRAL LACERAT
8002	80020	CLOSED FRACTURE OF VAULT OF SKULL WITH SUBARACHNOID, SU
8003	80030	CLOSED FRACTURE OF VAULT OF SKULL WITH OTHER AND UNSPEC
8004	80040	CLOSED FRACTURE OF VAULT OF SKULL WITH INTRACRANIAL INJ
8005	80050	OPEN FRACTURE OF VAULT OF SKULL WITHOUT MENTION OF INTR

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8006	80060	OPEN FRACTURE OF VAULT OF SKULL WITH CEREBRAL LACERATIO
8007	80070	OPEN FRACTURE OF VAULT OF SKULL WITH SUBARACHNOID, SUBD
8008	80080	OPEN FRACTURE OF VAULT OF SKULL WITH OTHER AND UNSPECIF
8009	80090	OPEN FRACTURE OF VAULT OF SKULL WITH INTRACRANIAL INJUR
8010	80109	CLOSED FRACTURE OF BASE OF SKULL WITHOUT MENTION OF INT
8011	80110	CLOSED FRACTURE OF BASE OF SKULL WITH CEREBRAL LACERATI
8012	80120	CLOSED FRACTURE OF BASE OF SKULL WITH SUBARACHNOID, SUB
8013	80130	CLOSED FRACTURE OF BASE OF SKULL WITH OTHER AND UNSPECI
8014	80140	CLOSED FRACTURE OF BASE OF SKULL WITH INTRACRANIAL INJU
8015	80150	OPEN FRACTURE OF BASE OF SKULL WITHOUT MENTION OF INTRA
8016	80160	OPEN FRACTURE OF BASE OF SKULL WITH CEREBRAL LACERATION
8017	80170	OPEN FRACTURE OF BASE OF SKULL WITH SUBARACHNOID, SUBDU
8018	80180	OPEN FRACTURE OF BASE OF SKULL WITH OTHER AND UNSPECIFI
8019	80190	OPEN FRACTURE OF BASE OF SKULL WITH INTRACRANIAL INJURY
8022	80220	CLOSED FRACTURE OF UNSPECIFIED SITE OF MANDIBLE
8023	80230	OPEN FRACTURE OF UNSPECIFIED SITE OF MANDIBLE
8030	80300	OTHER CLOSED SKULL FRACTURE WITHOUT MENTION OF INTRACRA
8031	80310	OTHER CLOSED SKULL FRACTURE WITH CEREBRAL LACERATION AN
8032	80320	OTHER CLOSED SKULL FRACTURE WITH SUBARACHNOID, SUBDURAL
8033	80330	OTHER CLOSED SKULL FRACTURE WITH OTHER AND UNSPECIFIED
8034	80340	OTHER CLOSED SKULL FRACTURE WITH INTRACRANIAL INJURY OF
8035	80350	OTHER OPEN SKULL FRACTURE WITHOUT MENTION OF INJURY, WI
8036	80360	OTHER OPEN SKULL FRACTURE WITH CEREBRAL LACERATION AND
8037	80370	OTHER OPEN SKULL FRACTURE WITH SUBARACHNOID, SUBDURAL,
8038	80380	OTHER OPEN SKULL FRACTURE WITH OTHER AND UNSPECIFIED IN
8039	80390	OTHER OPEN SKULL FRACTURE WITH INTRACRANIAL INJURY OF O
8040	80400	CLOSED FRACTURES INVOLVING SKULL OR FACE WITH OTHER BON
8041	80410	CLOSED FRACTURES INVOLVING SKULL OR FACE WITH OTHER BON
8042	80420	CLOSED FRACTURES INVOLVING SKULL OR FACE WITH OTHER BON
8043	80430	CLOSED FRACTURES INVOLVING SKULL OR FACE WITH OTHER BON
8044	80440	CLOSED FRACTURES INVOLVING SKULL OR FACE WITH OTHER BON
8045	80450	OPEN FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES
8046	80460	OPEN FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES
8047	80470	OPEN FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES
8048	80480	OPEN FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES
8050	80500	CLOSED FRACTURE OF CERVICAL VERTEBRA, UNSPECIFIED LEVEL
8051	80510	OPEN FRACTURE OF CERVICAL VERTEBRA, UNSPECIFIED LEVEL
8060	80600	CLOSED FRACTURE OF C1-C4 LEVEL WITH UNSPECIFIED SPINAL
8061	80610	OPEN FRACTURE OF C1-C4 LEVEL WITH UNSPECIFIED SPINAL CO
8062	80620	CLOSED FRACTURE OF T1-T6 LEVEL WITH UNSPECIFIED SPINAL
8063	80630	OPEN FRACTURE OF T1-T6 LEVEL WITH UNSPECIFIED SPINAL CO
8066	80660	CLOSED FRACTURE OF SACRUM AND COCCYX WITH UNSPECIFIED S
8067	80670	OPEN FRACTURE OF SACRUM AND COCCYX WITH UNSPECIFIED SPI
8070	80709	CLOSED FRACTURE OF MULTIPLE RIBS, UNSPECIFIED
8071	80710	OPEN FRACTURE OF RIB(S), UNSPECIFIED
8084	80849	CLOSED FRACTURE OF OTHER SPECIFIED PART OF PELVIS
8085	80859	OPEN FRACTURE OF OTHER SPECIFIED PART OF PELVIS

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8100	81000	CLOSED FRACTURE OF CLAVICLE, UNSPECIFIED PART
8101	81010	OPEN FRACTURE OF CLAVICLE, UNSPECIFIED PART
8110	81103	CLOSED FRACTURE OF GLENOID CAVITY AND NECK OF SCAPULA
8111	81110	OPEN FRACTURE OF SCAPULA, UNSPECIFIED PART
8120	81200	FRACTURE OF UNSPECIFIED PART OF UPPER END OF HUMERUS, C
8121	81210	FRACTURE OF UNSPECIFIED PART OF UPPER END OF HUMERUS, O
8122	81220	FRACTURE OF UNSPECIFIED PART OF HUMERUS, CLOSED
8123	81230	FRACTURE OF UNSPECIFIED PART OF HUMERUS, OPEN
8124	81240	FRACTURE OF UNSPECIFIED PART OF LOWER END OF HUMERUS, C
8125	81250	FRACTURE OF UNSPECIFIED PART OF LOWER END OF HUMERUS, O
8130	81305	FRACTURE OF HEAD OF RADIUS, CLOSED
8131	81310	OPEN FRACTURE OF UPPER END OF FOREARM, UNSPECIFIED
8132	81321	FRACTURE OF SHAFT OF RADIUS (ALONE), CLOSED
8133	81330	FRACTURE OF SHAFT OF RADIUS OR ULNA, UNSPECIFIED, OPEN
8134	81342	OTHER CLOSED FRACTURES OF DISTAL END OF RADIUS (ALONE)
8135	81354	FRACTURE OF LOWER END OF RADIUS WITH ULNA, OPEN
8138	81381	FRACTURE OF UNSPECIFIED PART OF RADIUS (ALONE), CLOSED
8139	81392	FRACTURE OF UNSPECIFIED PART OF ULNA (ALONE), OPEN
8140	81400	CLOSED FRACTURE OF CARPAL BONE, UNSPECIFIED
8141	81410	OPEN FRACTURE OF CARPAL BONE, UNSPECIFIED
8150	81500	CLOSED FRACTURE OF METACARPAL BONE(S), SITE UNSPECIFIED
8151	81510	OPEN FRACTURE OF METACARPAL BONE(S), SITE UNSPECIFIED
8160	81600	CLOSED FRACTURE OF PHALANX OR PHALANGES OF HAND, UNSPEC
8161	81610	OPEN FRACTURE OF PHALANX OR PHALANGES OF HAND, UNSPECIF
8200	82009	OTHER TRANSCERVICAL FRACTURE OF FEMUR, CLOSED
8201	82019	OTHER TRANSCERVICAL FRACTURE OF FEMUR, OPEN
8202	82021	FRACTURE OF INTERTROCHANTERIC SECTION OF FEMUR, CLOSED
8203	82030	FRACTURE OF UNSPECIFIED TROCHANTERIC SECTION OF FEMUR,
8210	82100	FRACTURE OF UNSPECIFIED PART OF FEMUR, CLOSED
8211	82110	FRACTURE OF UNSPECIFIED PART OF FEMUR, OPEN
8212	82120	FRACTURE OF LOWER END OF FEMUR, UNSPECIFIED PART, CLOSE
8213	82130	FRACTURE OF LOWER END OF FEMUR, UNSPECIFIED PART, OPEN
8230	82300	CLOSED FRACTURE OF UPPER END OF TIBIA
8231	82310	OPEN FRACTURE OF UPPER END OF TIBIA
8232	82320	CLOSED FRACTURE OF SHAFT OF TIBIA
8233	82330	OPEN FRACTURE OF SHAFT OF TIBIA
8238	82380	CLOSED FRACTURE OF UNSPECIFIED PART OF TIBIA
8239	82392	OPEN FRACTURE OF UNSPECIFIED PART OF FIBULA WITH TIBIA
8252	82525	FRACTURE OF METATARSAL BONE(S), CLOSED
8253	82535	FRACTURE OF METATARSAL BONE(S), OPEN
8310	83100	CLOSED DISLOCATION OF SHOULDER, UNSPECIFIED SITE
8311	83110	OPEN DISLOCATION OF SHOULDER, UNSPECIFIED
8320	83200	CLOSED DISLOCATION OF ELBOW, UNSPECIFIED SITE
8321	83210	OPEN DISLOCATION OF ELBOW, UNSPECIFIED SITE
8330	83309	CLOSED DISLOCATION OF OTHER PART OF WRIST
8331	83310	OPEN DISLOCATION OF WRIST, UNSPECIFIED PART
8340	83402	CLOSED DISLOCATION OF INTERPHALANGEAL (JOINT), HAND

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
8341	83410	OPEN DISLOCATION OF FINGER, UNSPECIFIED PART
8350	83500	CLOSED DISLOCATION OF HIP, UNSPECIFIED SITE
8351	83510	OPEN DISLOCATION OF HIP, UNSPECIFIED SITE
8365	83650	CLOSED DISLOCATION OF KNEE, UNSPECIFIED PART
8366	83660	DISLOCATION OF KNEE, UNSPECIFIED PART, OPEN
8380	83809	CLOSED DISLOCATION OF OTHER PART OF FOOT
8381	83810	OPEN DISLOCATION OF FOOT, UNSPECIFIED PART
8390	83901	CLOSED DISLOCATION, FIRST CERVICAL VERTEBRA
8391	83910	OPEN DISLOCATION, CERVICAL VERTEBRA, UNSPECIFIED
8392	83920	CLOSED DISLOCATION, LUMBAR VERTEBRA
8393	83930	OPEN DISLOCATION, LUMBAR VERTEBRA
8394	83942	CLOSED DISLOCATION, SACRUM
8395	83950	OPEN DISLOCATION, VERTEBRA, UNSPECIFIED SITE
8396	83969	CLOSED DISLOCATION, OTHER LOCATION
8397	83971	OPEN DISLOCATION, STERNUM
8420	84200	SPRAIN OF UNSPECIFIED SITE OF WRIST
8421	84210	SPRAIN OF UNSPECIFIED SITE OF HAND
8450	84500	UNSPECIFIED SITE OF ANKLE SPRAIN
8451	84510	UNSPECIFIED SITE OF FOOT SPRAIN
8484	84840	STERNUM SPRAIN, UNSPECIFIED PART
8510	85100	CORTEX (CEREBRAL) CONTUSION WITHOUT MENTION OF OPEN
8511	85110	CORTEX (CEREBRAL) CONTUSION WITH OPEN INTRACRANIAL WOUN
8512	85120	CORTEX (CEREBRAL) LACERATION WITHOUT MENTION OF OPEN
8513	85130	CORTEX (CEREBRAL) LACERATION WITH OPEN INTRACRANIAL WOU
8514	85140	CEREBELLAR OR BRAIN STEM CONTUSION WITHOUT MENTION OF O
8515	85150	CEREBELLAR OR BRAIN STEM CONTUSION WITH OPEN INTRACRANI
8516	85160	CEREBELLAR OR BRAIN STEM LACERATION WITHOUT MENTION OF
8517	85170	CEREBELLAR OR BRAIN STEM LACERATION WITH OPEN INTRACRAN
8518	85180	OTHER AND UNSPECIFIED CEREBRAL LACERATION AND CONTUSION
8519	85190	OTHER AND UNSPECIFIED CEREBRAL LACERATION AND CONTUSION
8520	85200	SUBARACHNOID HEMORRHAGE FOLLOWING INJURY, WITHOUT MENTI
8521	85210	SUBARACHNOID HEMORRHAGE FOLLOWING INJURY, WITH OPEN INT
8522	85220	SUBDURAL HEMORRHAGE FOLLOWING INJURY, WITHOUT MENTION O
8523	85230	SUBDURAL HEMORRHAGE FOLLOWING INJURY, WITH OPEN INTRACR
8524	85240	EXTRADURAL HEMORRHAGE FOLLOWING INJURY, WITHOUT MENTION
8525	85250	EXTRADURAL HEMORRHAGE FOLLOWING INJURY, WITH OPEN INTRA
8530	85300	OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE FOLLOWING
8531	85310	OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE FOLLOWING
8540	85400	INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE, WI
8541	85410	INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE, WI
8610	86100	UNSPECIFIED INJURY OF HEART WITHOUT MENTION OF OPEN WOU
8611	86110	UNSPECIFIED INJURY OF HEART WITH OPEN WOUND INTO THORAX
8612	86121	CONTUSION OF LUNG WITHOUT OPEN WOUND INTO THORAX
8613	86130	UNSPECIFIED INJURY OF LUNG WITH OPEN WOUND INTO THORAX
8622	86221	INJURY TO BRONCHUS WITHOUT OPEN WOUND INTO CAVITY
8623	86231	INJURY TO BRONCHUS WITH OPEN WOUND INTO CAVITY
8632	86320	INJURY TO SMALL INTESTINE, UNSPECIFIED SITE, WITHOUT OP

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
8633	86330	INJURY TO SMALL INTESTINE, UNSPECIFIED SITE, WITH OPEN
8634	86340	INJURY TO COLON, UNSPECIFIED SITE, WITHOUT MENTION OF O
8635	86350	INJURY TO COLON, UNSPECIFIED SITE, WITH OPEN WOUND INTO
8638	86380	INJURY TO GASTROINTESTINAL TRACT, UNSPECIFIED SITE, WIT
8639	86390	INJURY TO GASTROINTESTINAL TRACT, UNSPECIFIED SITE, WIT
8640	86400	UNSPECIFIED INJURY TO LIVER WITHOUT MENTION OF OPEN
8641	86410	UNSPECIFIED INJURY TO LIVER WITH OPEN WOUND INTO CAVITY
8650	86501	HEMATOMA OF SPLEEN, WITHOUT RUPTURE OF CAPSULE, WITHOUT
8651	86510	UNSPECIFIED INJURY TO SPLEEN WITH OPEN WOUND INTO CAVIT
8660	86601	HEMATOMA OF KIDNEY, WITHOUT RUPTURE OF CAPSULE, WITHOUT
8661	86610	UNSPECIFIED INJURY TO KIDNEY WITH OPEN WOUND INTO CAVIT
8680	86800	INJURY TO UNSPECIFIED INTRA-ABDOMINAL ORGAN WITHOUT MEN
8681	86810	INJURY TO UNSPECIFIED INTRA-ABDOMINAL ORGAN, WITH OPEN
8720	87200	OPEN WOUND OF EXTERNAL EAR, UNSPECIFIED SITE, UNCOMPLIC
8721	87210	OPEN WOUND OF EXTERNAL EAR, UNSPECIFIED SITE, COMPLICAT
8726	87261	OPEN WOUND OF EAR DRUM, UNCOMPLICATED
8727	87271	OPEN WOUND OF EAR DRUM, COMPLICATED
8732	87320	OPEN WOUND OF NOSE, UNSPECIFIED SITE, UNCOMPLICATED
8733	87330	OPEN WOUND OF NOSE, UNSPECIFIED SITE, COMPLICATED
8734	87342	OPEN WOUND OF FOREHEAD, UNCOMPLICATED
8735	87350	OPEN WOUND OF FACE, UNSPECIFIED SITE, COMPLICATED
8736	87364	OPEN WOUND OF TONGUE AND FLOOR OF MOUTH, UNCOMPLICATED
8737	87370	OPEN WOUND OF MOUTH, UNSPECIFIED SITE, COMPLICATED
8740	87400	OPEN WOUND OF LARYNX WITH TRACHEA, UNCOMPLICATED
8741	87410	OPEN WOUND OF LARYNX WITH TRACHEA, COMPLICATED
8800	88000	OPEN WOUND OF SHOULDER REGION, WITHOUT MENTION OF COMPL
8801	88010	OPEN WOUND OF SHOULDER REGION, COMPLICATED
8802	88020	OPEN WOUND OF SHOULDER REGION, WITH TENDON INVOLVEMENT
8810	88100	OPEN WOUND OF FOREARM, WITHOUT MENTION OF COMPLICATION
8811	88111	OPEN WOUND OF ELBOW, COMPLICATED
8812	88120	OPEN WOUND OF FOREARM, WITH TENDON INVOLVEMENT
9000	90000	INJURY TO CAROTID ARTERY, UNSPECIFIED
9008	90081	INJURY TO EXTERNAL JUGULAR VEIN
9014	90140	INJURY TO PULMONARY VESSEL(S), UNSPECIFIED
9018	90181	INJURY TO INTERCOSTAL ARTERY OR VEIN
9021	90210	INJURY TO INFERIOR VENA CAVA, UNSPECIFIED
9022	90220	INJURY TO CELIAC AND MESENTERIC ARTERIES, UNSPECIFIED
9023	90231	INJURY TO SUPERIOR MESENTERIC VEIN AND PRIMARY SUBDIVIS
9024	90240	INJURY TO RENAL VESSEL(S), UNSPECIFIED
9025	90250	INJURY TO ILIAC VESSEL(S), UNSPECIFIED
9028	90281	INJURY TO OVARIAN ARTERY
9030	90300	INJURY TO AXILLARY VESSEL(S), UNSPECIFIED
9044	90440	INJURY TO POPLITEAL VESSEL(S), UNSPECIFIED
9045	90450	INJURY TO TIBIAL VESSEL(S), UNSPECIFIED
9230	92300	CONTUSION OF SHOULDER REGION
9231	92310	CONTUSION OF FOREARM
9232	92320	CONTUSION OF HAND(S)

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
9240	92400	CONTUSION OF THIGH
9241	92410	CONTUSION OF LOWER LEG
9242	92420	CONTUSION OF FOOT
9261	92611	CRUSHING INJURY OF BACK
9270	92700	CRUSHING INJURY OF SHOULDER REGION
9271	92710	CRUSHING INJURY OF FOREARM
9272	92720	CRUSHING INJURY OF HAND(S)
9280	92800	CRUSHING INJURY OF THIGH
9281	92810	CRUSHING INJURY OF LOWER LEG
9282	92820	CRUSHING INJURY OF FOOT
9410	94103	BURN OF UNSPECIFIED DEGREE OF LIP(S)
9411	94110	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF UNSPECIFIED SITE
9412	94120	BLISTERS, WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGRE
9413	94130	FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS)
9414	94140	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP
9415	94150	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP
9420	94202	BURN OF UNSPECIFIED DEGREE OF CHEST WALL, EXCLUDING
9421	94210	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF UNSPECIFIED
9422	94220	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE
9423	94230	FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS)
9424	94240	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN
9425	94250	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP
9430	94300	BURN OF UNSPECIFIED DEGREE OF UNSPECIFIED SITE OF UPPER
9431	94310	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF
9432	94320	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE
9433	94330	FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS)
9434	94340	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN
9435	94350	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP T
9440	94400	BURN OF UNSPECIFIED DEGREE OF UNSPECIFIED SITE OF HAND
9441	94410	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF UNSPECIFIED SITE
9442	94420	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE
9443	94431	FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS)
9444	94440	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP T
9445	94450	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP T
9450	94506	BURN OF UNSPECIFIED DEGREE OF THIGH (ANY PART)
9451	94510	ERYTHEMA DUE TO BURN (FIRST DEGREE) OF UNSPECIFIED SITE
9452	94520	BLISTERS, EPIDERMAL LOSS (SECOND DEGREE) OF UNSPECIFIED
9453	94530	FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS)
9454	94540	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN
9455	94550	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN
9480	94800	BURN (ANY DEGREE) INVOLVING LESS THAN 10 PERCENT OF BOD
9481	94810	BURN (ANY DEGREE) INVOLVING 10-19 PERCENT OF BODY SURFA
9482	94820	BURN (ANY DEGREE) INVOLVING 20-29 PERCENT OF BODY
9483	94830	BURN (ANY DEGREE) INVOLVING 30-39 PERCENT OF BODY
9484	94840	BURN (ANY DEGREE) INVOLVING 40-49 PERCENT OF BODY
9485	94850	BURN (ANY DEGREE) INVOLVING 50-59 PERCENT OF BODY
9486	94860	BURN (ANY DEGREE) INVOLVING 60-69 PERCENT OF BODY

CHAM-PUS CODE	ICD-9-CM CODE	TITLE
9487	94870	BURN (ANY DEGREE) INVOLVING 70-79 PERCENT OF BODY SURFA
9488	94880	BURN (ANY DEGREE) INVOLVING 80-89 PERCENT OF BODY SURFA
9489	94890	BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY
9520	95200	C1-C4 LEVEL SPINAL CORD INJURY, UNSPECIFIED
9521	95210	T1-T6 LEVEL SPINAL CORD INJURY, UNSPECIFIED
9650	96500	POISONING BY OPIUM (ALKALOIDS), UNSPECIFIED
9958	99581	ADULT MALTREATMENT SYNDROME
9960	99601	MECHANICAL COMPLICATION DUE TO CARDIAC PACEMAKER (ELECT
9963	99632	MECHANICAL COMPLICATION DUE TO INTRAUTERINE CONTRACEPTI
9965	99659	MECHANICAL COMPL OTHER IMPLANT & INTERNAL DEVICE NEC
9966	99660	INFECT & INFLAMMATRY REACT DUE TO UNSPEC DEVICE,IMPLANT
9967	99670	OTHER COMPLICATION DUE TO UNSPEC DEVICE,IMPLANT,GRAFT
9968	99680	COMPLICATIONS OF TRANSPLANTED ORGAN, UNSPECIFIED
9969	99690	COMPLICATIONS OF UNSPECIFIED REATTACHED EXTREMITY
9976	99769	OTHER LATE AMPUTATION STUMP COMPLICATION

APPENDIX F

PROCEDURE TRANSLATION TABLE

APPENDIX F

Procedure Translation Table

CHAMPUS-UNIQUE CODES		MAPPED TO CPT-4	
CODE	TITLE	CODE	TITLE
06870	PHYSICAL THERAPY AIDS, PURCHASE	99070	SUPPLIES,EQPMT
06871	PHYSICAL THERAPY AIDS, RENTAL	99070	SUPPLIES,EQPMT
06872	PURCHASE, BED AND BEDSIDE CARE ITEMS	99070	SUPPLIES,EQPMT
06873	RENTAL, BED AND BEDSIDE CARE ITEMS	99070	SUPPLIES,EQPMT
06874	PURCHASE, DIALYSIS EQUIPMENT AND SUPPLIES	99070	SUPPLIES,EQPMT
06875	RENTAL, DIALYSIS EQUIPMENT AND SUPPLIES	99070	SUPPLIES,EQPMT
06876	PURCHASE, RESPIRATORY EQUIPMENT AND SUPPLI	99070	SUPPLIES,EQPMT
06877	RENTAL, RESPIRATORY EQUIPMENT AND SUPPLIES	99070	SUPPLIES,EQPMT
06878	PURCHASE, OXYGEN EQUIPMENT AND SUPPLIES	99070	SUPPLIES,EQPMT
06879	RENTAL, OXYGEN EQUIPMENT AND SUPPLIES	99070	SUPPLIES,EQPMT
06880	PURCHASE, ORTHOPEDIC DEVICES AND ACCESSORI	99070	SUPPLIES,EQPMT
06881	RENTAL, ORTHOPEDIC DEVICES AND ACCESSORIES	99070	SUPPLIES,EQPMT
06882	PURCHASE, CUSTOM ANCILLARY BODY SUPPORTS	99070	SUPPLIES,EQPMT
06883	RENTAL, CUSTOM ANCILLARY BODY SUPPORTS	99070	SUPPLIES,EQPMT
06884	PURCHASE, OSTOMY SUPPLIES	99070	SUPPLIES,EQPMT
06886	PURCHASE, WHEELCHAIRS AND ATTACHMENTS	99070	SUPPLIES,EQPMT
06887	RENTAL, WHEELCHAIRS AND ATTACHMENTS	99070	SUPPLIES,EQPMT
06888	PURCHASE, NUTRITION EQUIPMENT AND SUPPLIES	99070	SUPPLIES,EQPMT
06890	PURCHASE, MONITORING EQUIPMENT AND SUPPLIE	99070	SUPPLIES,EQPMT
06891	RENTAL, MONITORING EQUIPMENT AND SUPPLIES	99070	SUPPLIES,EQPMT
06892	PURCHASE, CHEMOTHERAPY EQUIP & SUP(EXCLUD	99070	SUPPLIES,EQPMT
06894	PURCHASE, BREAST PROSTHESES	99070	SUPPLIES,EQPMT
06896	PURCHASE, HEARING AIDS	99070	SUPPLIES,EQPMT
06897	REPAIRS FOR HEARING AIDS	99070	SUPPLIES,EQPMT
06898	PURCHASE, TORSO ORTHOTIC APPLIANCES AND SU	99070	SUPPLIES,EQPMT
06899	RENTAL, TORSO ORTHOTIC APPLIANCES AND SUPP	99070	SUPPLIES,EQPMT
06902	PURCHASE, LOWER EXTREMITY ORTHOSIS AND SUP	99070	SUPPLIES,EQPMT
06903	RENTAL, LOWER EXTREMITY ORTHOSIS AND SUPPL	99070	SUPPLIES,EQPMT
06906	PURCHASE, HIP AND SPECIAL ORTHOSES AND SUP	99070	SUPPLIES,EQPMT
06907	RENTAL, HIP AND SPECIAL ORTHOSES AND SUPPL	99070	SUPPLIES,EQPMT
06910	PURCHASE, KNEE ORTHOSES	99070	SUPPLIES,EQPMT
06911	RENTAL, KNEE ORTHOSES	99070	SUPPLIES,EQPMT
06912	PURCHASE, FOOT APPLIANCES AND MODIFICATION	99070	SUPPLIES,EQPMT
06913	RENTAL, FOOT APPLIANCES AND MODIFICATIONS	99070	SUPPLIES,EQPMT
06914	PURCHASE, UPPER EXTREMITY ORTHOSIS AND APP	99070	SUPPLIES,EQPMT
06915	RENTAL, UPPER EXTREMITY ORTHOSIS AND APPLI	99070	SUPPLIES,EQPMT
06916	PURCHASE, CASTING PROCEDURE ORTHOTIC	99070	SUPPLIES,EQPMT
06917	RENTAL, CASTING PROCEDURE ORTHOTIC	99070	SUPPLIES,EQPMT
06918	REPAIRS FOR ORTHOSES	99070	SUPPLIES,EQPMT
06920	PURCHASE, PROSTHETICS LOWER AND SUPPLIES	99070	SUPPLIES,EQPMT
06921	RENTAL, PROSTHETICS LOWER AND SUPPLIES	99070	SUPPLIES,EQPMT
06924	PURCHASE, PROSTHETICS UPPER AND SUPPLIES	99070	SUPPLIES,EQPMT
06925	RENTAL, PROSTHETICS UPPER AND SUPPLIES	99070	SUPPLIES,EQPMT

CHAMPUS-UNIQUE CODES		MAPPED TO CPT-4	
CODE	TITLE	CODE	TITLE
06928	PURCHASE, TERMINAL DEVICES,HANDS,GLOVES,AT	99070	SUPPLIES,EQPMT
06929	RENTAL, TERMINAL DEVICES,HANDS,GLOVES,ATTA	99070	SUPPLIES,EQPMT
06930	PURCHASE, STUMPS, SOX, SHRINKERS, AND PADS	99070	SUPPLIES,EQPMT
06932	PURCHASE, UNLISTED PROSTHESES	99070	SUPPLIES,EQPMT
06933	RENTAL, UNLISTED PROSTHESES	99070	SUPPLIES,EQPMT
06934	REPAIRS FOR PROSTHESES	99070	SUPPLIES,EQPMT
06936	PURCHASE, ELASTIC AND MISCELLANEOUS SUPPOR	99070	SUPPLIES,EQPMT
06938	PURCHASE, EYE PROSTHESES, LENSES, AND FRAM	92390	SUPPLY OF SPECTACLES
06940	PURCHASE, ORTHOPTIC DEVICES	99070	SUPPLIES,EQPMT
06942	PURCHASE, OTHER EQUIPMENT AND SUPPLIES	99070	SUPPLIES,EQPMT
06943	RENTAL, OTHER EQUIPMENT AND SUPPLIES	99070	SUPPLIES,EQPMT
06944	PURCHASE, CARDIORESPIRATORY MONITOR	99070	SUPPLIES,EQPMT
06945	RENTAL, CARDIORESPIRATORY MONITOR	99070	SUPPLIES,EQPMT
06946	PURCHASE, CARDIORESPIRATORY MONITOR-RELATE	99070	SUPPLIES,EQPMT
09977	PURCHASE, WIGS AND HAIRPIECES	99070	SUPPLIES,EQPMT
59421	PRENATAL CARE; SINGLE VST (WHEN NOT GLOBAL	59420	ANTEPARTUM CARE ONLY
76107	COMPUTERIZED AXIAL TOMOGRAPHY, ANY BODY AR	76070	COMPUTERIZED TOMOGRAPHY
90098	CARDIORESPIRATORY MONITOR-RELATED PROF SER	99150	PROLONG PHYSICIAN ATTND
90199	SERVICES OF A H9OME HEALTH AIDE/HOMEMAKER	90430	NURS HM VST,EST PNT,MIN
90593	WHOLE BLOOD CHARGES		
90594	PROFESSIONAL COMPONENTS CHARGE	90015	OFF VST,NEW PNT,INTERM
90595	PHYSICIAN'S CHARGE	90015	OFF VST,NEW PNT,INTERM
90596	RECOVERY ROOM CHARGE	99173	CRITICAL CARE,INTERMED
90597	OPERATING ROOM CHARGE	99160	CRITICAL CARE, INITIAL
90599	EMERGENCY ROOM CHARGE	90515	EMER DPT,NEW PNT,INTER
90809	GROUP PSYCHOTHERAPY(4-10 PRSNS,PER SESSION	90853	GRP MEDICAL PSYCHOTHER
90810	GROUP PSYCHOTHERAPY(4-10 PRSNS,PER SESSION	90853	GRP MEDICAL PSYCHOTHER
90811	GROUP PSYCHOTHERAPY(4-10 PRSNS,PER SESSION	90853	GRP MEDICAL PSYCHOTHER
90812	FAM PSYCHOTHER,2 FAM MEM,CONT MED DIAG EVA	90847	FMLY MEDICL PSYCHOTHER
90813	FAM PSYCHOTHER,2 FAM MEM,CONT MED DIAG EVA	90847	FMLY MEDICL PSYCHOTHER
90814	FAM PSYCHOTHER,2 FAM MEM,CONT MED DIAG EVA	90847	FMLY MEDICL PSYCHOTHER
90815	FAM PSYCHOTHER,3 OR MORE FAM MEM MED DIAG	90847	FMLY MEDICL PSYCHOTHER
90816	FAM PSYCHOTHER,3 OR MORE FAM MEM MED DIAG	90847	FMLY MEDICL PSYCHOTHER
90817	FAM PSYCHOTHER,3 OR MORE FAM MEM MED DIAG	90847	FMLY MEDICL PSYCHOTHER
90818	MULT FAM GRP THERAPY,CONT MED DIAG EVAL,45	90849	MULT FMLY GRP PSYCHOTH
90819	MULT FAM GRP THERAPY,CONT MED DIAG EVAL,<4	90849	MULT FMLY GRP PSYCHOTH
90820	MULT FAM GRP THERAPY,CONT MED DIAG EVAL,61	90849	MULT FMLY GRP PSYCHOTH
90831	PHONE CONSULT ABOUT PNT FOR MENTAL HEALTH	90899	UNLISTED PSYCHIATR SVC
90875	ANCILLARY THERAPY-MUSIC,DANCE,RECREATIONAL	90899	UNLISTED PSYCHIATR SVC
92190	NONCOVERED REFRACTIVE SVCS,PART OF EYE EXA	92499	UNLISTED OPHTHAL SVC
92845	SPVSN,TRMT TEAM FOR OP CARE,INP CARE,PART	90215	HOSP CARE,INITIAL,INTER
92860	MARATHON THERAPY	90899	UNLISTED PSYCHIATR SVC
92870	CRISIS INTERVENTION - INDIVIDUAL	90841	INDIV MED PSYCHOTHERAPY
92871	CRISIS INTERVENTION - FAMILY	90847	FMLY MED PSYCHOTHERAPY
92891	PARTIAL HOSPITALIZATION, DAY TIME CARE	90899	UNLISTED PSYCHIATR SVC
92892	PARTIAL HOSPITALIZATION, HALF DAY (4 HRS O	90899	UNLISTED PSYCHIATR SVC
92893	PARTIAL HOSPITALIZATION, NIGHT TIME CARE	90899	UNLISTED PSYCHIATR SVC
97660	BRF OSTEOPATHIC MANIPULATV THERAPY,UP TO 2S	97260	MANIPULATION,ONE AREA

CHAMPUS-UNIQUE CODES		MAPPED TO CPT-4	
CODE	TITLE	CODE	TITLE
97661	LIM OSTEOPATHIC MANIPULATIVE THERAPY,UP TO	97261	MANIPULATN,ADDED AREAS
97662	INTER OSTEOPATHIC MANIPULATIVE THER, UP TO	97261	MANIPULATN,ADDED AREAS
97663	EXTENDED OSTEOPATHIC MANIP THERAPY, UP TO	97261	MANIPULATN,ADDED AREAS
97664	COMPREHENSIVE OSTEOPATHIC MANIP THER,UP TO	97261	MANIPULATN,ADDED AREAS
98000	RESIDENTIAL CARE IN PUBLIC INSTITUTIONS	90340	SNF,SUBSEQNT CARE,BRF
98010	RESIDENTIAL CARE IN PRIVATE NON-PROFIT INS	90340	SNF,SUBSEQNT CARE,BRF
98030	PUBLIC SPECIAL SCHOOLS OR DAY CARE CENTERS	90430	CUSTOD CARE,EST PNT,MIN
98040	PRIVATE, NON-PROFIT SPECIAL SCHOOLS OR DAY	90430	CUSTOD CARE,EST PNT,MIN
98050	CENTERS,PRIVATE PROPRIETARY SPEC SCHOOLS,D	90430	CUSTOD CARE,EST PNT,MIN
98060	SPECIAL CLASS, PRIVATE NON-PROFIT	90699	UNLISTED MED SVC,GENERL
98210	SPECIALIZED CARE(NURS HOME,CONVALESCENT HO)	90699	UNLISTED MED SVC,GENERL
98240	VOCATIONAL TRNG SVCS FOR HOMEBOUND PNT	99199	UNLISTED SPEC SVC,RPT
98250	READING THERAPY	99199	UNLISTED SPEC SVC,RPT
98290	OTHER SPECIAL EDUCATION OR VOCATIONAL SERV	99199	UNLISTED SPEC SVC,RPT
98305	AIR AMBULANCE SERVICE	99082	UNUSUAL TRAVEL
98310	BASIC AMBULANCE SERVICE, AIR AMBULANCE	99082	UNUSUAL TRAVEL
98311	RETURN TRIP, AIR AMBULANCE	99082	UNUSUAL TRAVEL
98315	MILEAGE, AIR AMBULANCE SERVICE	99070	SUPPLIES,EQPMT
98317	OXYGEN, AMBULANCE SERVICE	99070	SUPPLIES,EQPMT
98318	MISCELLANEOUS SERVICES,AIR AMBULANCE	99082	UNUSUAL TRAVEL
98320	TRANSPORTATION FOR HANDICAPPED	99082	UNUSUAL TRAVEL
98330	ADVANCED LIFE SUPPORT AMBULANCE	99082	UNUSUAL TRAVEL
98331	RETURN TRIP, AMBULANCE SERVICES	99082	UNUSUAL TRAVEL
98335	MILEAGE, AMBULANCE SERVICES	99070	SUPPLIES,EQPMT
98338	MISCELLANEOUS AMBULANCE SERVICES	99082	SUPPLIES,EQPMT
98410	NURSING CARE, HOME	99199	UNLISTED SPEC SVC,RPT
98420	NURSING CARE, OTHER	99199	UNLISTED SPEC SVC,RPT
98510	SPEECH EVALUATION	92506	EVAL,SPEECH,LANG,HEARNG
98520	SPEECH THERAPY, INDIVIDUAL	92507	SPEECH,LANG,HEARNG THER
98530	SPEECH THERAPY, GROUP	92508	SPEECH,LANG,HEARNG THER
98710	OCCUPATIONAL THERAPY EVALUATION	97700	OFFICE VST,ORTHOTIC,ADL
98720	INDIVIDUAL OCCUPATIONAL THERAPY	97530	KINETIC ACTY,ROM,COORD
98730	GROUP OCCUPATIONAL THERAPY	97540	ADL
98790	OTHER SERVICES BY AN OCCUPATIONAL THERAPIS	97540	ADL
98930	VSTS REQUIRING EXTENDED TRANSP - HANDICAPP	99199	UNLISTED SPEC SVC,RPT
99088	OTHER ROOM, ANCILLARY AND DRUG CHARGES	99070	SUPPLIES,EQPMT
99590	BIRTHING CENTER-ALL-INCLUSIVE CHARGE-COMPL	59400	TOTAL OBSTETRIC CARE
99591	BIRTHING CENTER-ALL-INCLUSIVE CHARGE-PARTI	59420	ANTEPARTUM CARE ONLY
99592	HOSPITAL OUTPATIENT BIRTHING ROOM CHARGES	99070	SUPPLIES, EQPMT

APPENDIX G

TRANSLATION TABLE FOR CPT-4 VISIT CODES

APPENDIX G

Translation Table for CPT-4 Visit Codes

CPT-4 CODE	NEW CODE	TITLE
90000	99201	OFFICE/OUTPATIENT VISIT, NEW
90010	99202	OFFICE/OUTPATIENT VISIT, NEW
90015	99203	OFFICE/OUTPATIENT VISIT, NEW
90017	99204	OFFICE/OUTPATIENT VISIT, NEW
90020	99205	OFFICE/OUTPATIENT VISIT, NEW
90030	99211	OFFICE/OUTPATIENT VISIT, EST
90040	99212	OFFICE/OUTPATIENT VISIT, EST
90050	99213	OFFICE/OUTPATIENT VISIT, EST
90060	99213	OFFICE/OUTPATIENT VISIT, EST
90070	99214	OFFICE/OUTPATIENT VISIT, EST
90080	99215	OFFICE/OUTPATIENT VISIT, EST
90100	99341	HOME VISIT, NEW PATIENT
90110	99341	HOME VISIT, NEW PATIENT
90115	99342	HOME VISIT, NEW PATIENT
90117	99343	HOME VISIT, NEW PATIENT
90130	99351	HOME VISIT, ESTAB PATIENT
90140	99351	HOME VISIT, ESTAB PATIENT
90150	99352	HOME VISIT, ESTAB PATIENT
90160	99352	HOME VISIT, ESTAB PATIENT
90170	99353	HOME VISIT, ESTAB PATIENT
90200	99221	INITIAL HOSPITAL CARE
90215	99222	INITIAL HOSPITAL CARE
90220	99223	INITIAL HOSPITAL CARE
90225	99431	INITIAL CARE, NORMAL NEWBORN
90240	99231	SUBSEQUENT HOSPITAL CARE
90250	99231	SUBSEQUENT HOSPITAL CARE
90260	99231	SUBSEQUENT HOSPITAL CARE
90270	99232	SUBSEQUENT HOSPITAL CARE
90280	99233	SUBSEQUENT HOSPITAL CARE
90282	99433	NORMAL NEWBORN CARE,HOSPITAL
90292	99238	HOSPITAL DISCHARGE DAY
90300	99303	NURSING FACILITY CARE
90315	99302	NURSING FACILITY CARE
90320	99303	NURSING FACILITY CARE
90340	99311	NURSING FACILITY CARE,SUBSEQ
90350	99312	NURSING FACILITY CARE,SUBSEQ
90360	99312	NURSING FACILITY CARE,SUBSEQ
90370	99313	NURSING FACILITY CARE,SUBSEQ
90400	99321	REST HOME VISIT, NEW PATIENT
90410	99321	REST HOME VISIT, NEW PATIENT
90415	99322	REST HOME VISIT, NEW PATIENT
90420	99323	REST HOME VISIT, NEW PATIENT
90430	99331	REST HOME VISIT, ESTAB PAT

CPT-4 CODE	NEW CODE	TITLE
90440	99331	REST HOME VISIT, ESTAB PAT
90450	99332	REST HOME VISIT, ESTAB PAT
90460	99332	REST HOME VISIT, ESTAB PAT
90470	99333	REST HOME VISIT, ESTAB PAT
90500	99281	EMERGENCY DEPT VISIT
90505	99281	EMERGENCY DEPT VISIT
90510	99282	EMERGENCY DEPT VISIT
90515	99283	EMERGENCY DEPT VISIT
90517	99284	EMERGENCY DEPT VISIT
90520	99285	EMERGENCY DEPT VISIT
90530	99281	EMERGENCY DEPT VISIT
90540	99281	EMERGENCY DEPT VISIT
90550	99282	EMERGENCY DEPT VISIT
90560	99283	EMERGENCY DEPT VISIT
90570	99284	EMERGENCY DEPT VISIT
90580	99285	EMERGENCY DEPT VISIT
90590	99288	DIRECT ADVANCED LIFE SUPPORT
90600	99251	INITIAL INPATIENT CONSULT
90600	99241	OFFICE CONSULTATION
90605	99252	INITIAL INPATIENT CONSULT
90605	99242	OFFICE CONSULTATION
90610	99253	INITIAL INPATIENT CONSULT
90610	99243	OFFICE CONSULTATION
90620	99244	OFFICE CONSULTATION
90620	99254	INITIAL INPATIENT CONSULT
90630	99255	INITIAL INPATIENT CONSULT
90630	99245	OFFICE CONSULTATION
90640	99261	FOLLOW-UP INPATIENT CONSULT
90641	99262	FOLLOW-UP INPATIENT CONSULT
90642	99262	FOLLOW-UP INPATIENT CONSULT
90643	99263	FOLLOW-UP INPATIENT CONSULT
90650	99271	CONFIRMATORY CONSULTATION
90651	99272	CONFIRMATORY CONSULTATION
90652	99273	CONFIRMATORY CONSULTATION
90653	99274	CONFIRMATORY CONSULTATION
90654	99275	CONFIRMATORY CONSULTATION
90699	99499	UNLISTED E/M SERVICE
90755	99438	INFANT CARE TO AGE ONE YEAR
90757	99432	NEWBORN CARE NOT IN HOSPITAL
99062	99283	EMERGENCY DEPT VISIT
99064	99283	EMERGENCY DEPT VISIT
99065	99283	EMERGENCY DEPT VISIT
99152	99440	NEWBORN RESUSCITATION
99160	99291	CRITICAL CARE, FIRST HOUR
99162	99292	CRITICAL CARE, ADD'L 30 MIN

APPENDIX H

AMBULATORY PATIENT GROUP DEFINITIONS

APPENDIX H

Ambulatory Patient Group Definitions

Significant Outpatient procedure: One which is normally scheduled, constitutes the reason for visit, and dominates the time and resources expended during the visit. An example of a significant procedure is the excision of a skin lesion. Also included in significant outpatient procedures are significant tests such as a stress test.

Minor Outpatient Procedure: A procedure which is normally scheduled, **may** constitute the reason for visit, **may** dominate the time and resources expended during the visit, can be performed during a medical visit, and **does** increase the time and resources expended during the visit. Examples of minor outpatient procedures are immunizations and ECGs.

Incidental Outpatient Procedure: A procedure which is normally scheduled, **may** constitute the reason for the visit, **may** dominate the time and resources expended during the visit, **can be** performed during a medical visit and **does not** significantly increase the time and resources expended during the visit. An example of an incidental outpatient procedure is a venipuncture.

Ancillary Procedure: A procedure which is not normally performed by the primary physician, can be performed at separate time and site and is ordered by the primary physician to assist in patient diagnosis or treatment. Radiology, laboratory tests, anesthesia and pathology constitute ancillary procedures.

APPENDIX I

PRELIMINARY AMBULATORY PATIENT GROUP FREQUENCIES

APPENDIX I

Preliminary Ambulatory Patient Group Frequencies

APG	TITLE	FREQ	PERCENT	ADJUSTED FREQ	ADJUSTED PERCENT
1	PHOTOCHEMOTHERAPY	42	0.01	42	0.01
2	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATIO	83	0.02	83	0.02
3	SIMPLE INCISION AND DRAINAGE	377	0.09	377	0.08
4	COMPLEX INCISION AND DRAINAGE	27	0.01	27	0.01
5	DEBRIDEMENT OF NAILS	74	0.02	74	0.02
6	SIMPLE DEBRIDEMENT AND DESTRUCTION	2197	0.52	2197	0.49
7	SIMPLE EXCISION AND BIOPSY	1182	0.28	1182	0.26
8	COMPLEX EXCISION, BIOPSY AND DEBRIDEMEN	519	0.12	519	0.11
9	LIPECTOMY AND EXCISION WITH RECONSTRUCT	2	0.00	2	0.00
10	SIMPLE SKIN REPAIR	425	0.10	425	0.09
11	COMPLEX SKIN REPAIR	100	0.02	100	0.02
12	SKIN AND INTEGUMENT GRAFT, TRANSFER AND	163	0.04	163	0.04
27	SIMPLE INCISION AND EXCISION OF BREAST	215	0.05	215	0.05
28	BREAST RECONSTRUCTION AND MASTECTOMY	86	0.02	86	0.02
53	OCCUPATIONAL THERAPY	87	0.02	87	0.02
54	PHYSICAL THERAPY	5162	1.22	5162	1.14
55	DIAGNOSTIC ARTHROSCOPY	65	0.02	65	0.01
56	THERAPEUTIC ARTHROSCOPY	173	0.04	173	0.04
57	REPLACEMENT OF CAST	392	0.09	392	0.09
58	SPLINT, STRAPPING AND CAST REMOVAL	432	0.10	432	0.10
59	TREATMENT OF CLOSED FRACTURE & DISLOCAT	48	0.01	48	0.01
60	TREATMENT OF CLOSED FRACTURE & DISLOCAT	267	0.06	267	0.06
62	TREATMENT OF OPEN FRACTURE AND DISLOCAT	38	0.01	38	0.01
63	JOINT MANIPULATION UNDER ANESTHESIA	15	0.00	15	0.00
64	SIMPLE MAXILLOFACIAL PROCEDURES	139	0.03	139	0.03
65	COMPLEX MAXILLOFACIAL PROCEDURES	152	0.04	152	0.03
66	INCISION OF BONE, JOINT AND TENDON	80	0.02	80	0.02
67	BUNION PROCEDURES	124	0.03	124	0.03
68	EXCISION OF BONE, JOINT AND TENDON OF T	205	0.05	205	0.05
69	EXCISION OF BONE, JOINT & TENDON EXCEPT	47	0.01	47	0.01
70	ARTHROPLASTY	20	0.00	20	0.00
71	HAND AND FOOT TENOTOMY	22	0.01	22	0.00
72	SIMPLE HAND AND FOOT REPAIR EXCEPT TENO	108	0.03	108	0.02
73	COMPLEX HAND AND FOOT REPAIR	61	0.01	61	0.01
74	REPAIR,EXCEPT ARTHROTOMY,OF BONE,JOINT,	91	0.02	91	0.02
75	ARTHROTOMY EXCEPT OF HAND AND FOOT	27	0.01	27	0.01
76	ARTHROCENTESIS AND LIGAMENT OR TENDON I	888	0.21	888	0.20
77	SPEECH THERAPY	117	0.03	117	0.03
79	PULMONARY TEST AND THERAPY EXCEPT SPIRO	210	0.05	210	0.05
80	NEEDLE AND CATHETER BIOPSY, ASPIRATION,	45	0.01	45	0.01
81	SIMPLE ENDOSCOPY OF THE UPPER AIRWAY	125	0.03	125	0.03
82	COMPLEX ENDOSCOPY OF THE UPPER AIRWAY	40	0.01	40	0.01
83	SIMPLE ENDOSCOPY OF THE LOWER AIRWAY	83	0.02	83	0.02
84	COMPLEX ENDOSCOPY OF THE LOWER AIRWAY	16	0.00	16	0.00

NOTE: Frequencies include all APGs, prior to consolidation or packaging.

APG	TITLE	FREQ	PERCENT	ADJUSTED FREQ	ADJUSTED PERCENT
85	NASAL CAUTERIZATION AND PACKING	35	0.01	35	0.01
86	SIMPLE LIP, MOUTH AND SALIVARY GLAND PR	64	0.02	64	0.01
87	COMPLEX LIP, MOUTH AND SALIVARY GLAND P	44	0.01	44	0.01
88	MISCELLANEOUS SINUS, TRACHEAL AND LUNG	41	0.01	41	0.01
105	EXERCISE TOLERANCE TESTS	493	0.12	493	0.11
106	ECHOCARDIOGRAPHY	696	0.16	696	0.15
107	PHONOCARDIOGRAM	2	0.00	2	0.00
108	CARDIAC ELECTROPHYSIOLOGIC TESTS	38	0.01	38	0.01
109	VASCULAR CANNULATION WITH NEEDLE AND CA	267	0.06	267	0.06
110	DIAGNOSTIC CARDIAC CATHETERIZATION	319	0.08	319	0.07
111	ANGIOPLASTY AND TRANSCATHETER PROCEDURE	83	0.02	83	0.02
112	PACEMAKER INSERTION AND REPLACEMENT	8	0.00	8	0.00
113	REMOVAL AND REVISION OF PACEMAKER AND V	3	0.00	3	0.00
114	MINOR VASCULAR REPAIR AND FISTULA CONST	35	0.01	35	0.01
115	SECONDARY VARICOSE VEINS AND VASCULAR I	61	0.01	61	0.01
116	VASCULAR LIGATION	7	0.00	7	0.00
117	CARDIOPULMONARY RESUSCITATION AND INTUB	88	0.02	88	0.02
131	CHEMOTHERAPY BY INFUSION	.	.	.	.
132	CHEMOTHERAPY EXCEPT BY INFUSION	92	0.02	92	0.02
133	TRANSFUSION AND PHLEBOTOMY	87	0.02	87	0.02
134	BLOOD AND BLOOD PRODUCT EXCHANGE	7	0.00	7	0.00
135	DEEP LYMPH STRUCTURE AND THYROID PROCED	32	0.01	32	0.01
136	ALLERGY TESTS AND IMMUNOTHERAPY	723	0.17	723	0.16
157	ALIMENTARY TESTS AND SIMPLE TUBE PLACEM	18	0.00	18	0.00
158	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY	23	0.01	23	0.01
159	PERCUTANEOUS AND OTHER SIMPLE GASTROINT	28	0.01	28	0.01
160	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PRO	412	0.10	412	0.09
161	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BI	54	0.01	54	0.01
162	DIAGNOSTIC UPPER GASTROINTESTINAL ENDOS	340	0.08	340	0.08
163	THERAPEUTIC UPPER GASTROINTESTINAL ENDO	27	0.01	27	0.01
164	DIAGNOSTIC LOWER GASTROINTESTINAL ENDOS	242	0.06	242	0.05
165	THERAPEUTIC LOWER GASTROINTESTINAL ENDO	77	0.02	77	0.02
166	ERCP & OTHER MISCELLANEOUS GASTROINTEST	31	0.01	31	0.01
167	TONSIL AND ADENOID PROCEDURES	349	0.08	349	0.08
168	HERNIA AND HYDROCELE PROCEDURES	196	0.05	196	0.04
169	SIMPLE HEMORRHOID PROCEDURES	35	0.01	35	0.01
170	SIMPLE ANAL AND RECTAL PROCEDURES EXCEP	20	0.00	20	0.00
171	COMPLEX ANAL AND RECTAL PROCEDURES	50	0.01	50	0.01
172	PERITONEAL PROCEDURES AND CHANGE OF INT	21	0.00	21	0.00
173	MISCELLANEOUS DIGESTIVE PROCEDURES	28	0.01	28	0.01
183	SIMPLE URINARY STUDIES AND PROCEDURES	117	0.03	117	0.03
184	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTR	43	0.01	43	0.01
185	URINARY CATHETERIZATION AND DILATATION	211	0.05	211	0.05
186	HEMODIALYSIS	50	0.01	50	0.01
187	PERITONEAL DIALYSIS	4	0.00	4	0.00
188	SIMPLE CYSTOURETHROSCOPY	317	0.07	317	0.07
189	COMPLEX CYSTOURETHROSCOPY AND LITHOLAPA	100	0.02	100	0.02
190	PERCUTANEOUS RENAL ENDOSCOPY, CATHETERI	8	0.00	8	0.00

APG	TITLE	FREQ	PERCENT	ADJUSTED FREQ	ADJUSTED PERCENT
191	CYSTOTOMY	8	0.00	8	0.00
192	SIMPLE URETHRAL PROCEDURES	7	0.00	7	0.00
193	COMPLEX URETHRAL PROCEDURES	8	0.00	8	0.00
209	TESTICULAR AND EPIDIDYMAL PROCEDURES	39	0.01	39	0.01
210	INSERTION OF PENILE PROSTHESIS	4	0.00	4	0.00
211	COMPLEX PENILE PROCEDURES	11	0.00	11	0.00
212	SIMPLE PENILE PROCEDURES	457	0.11	457	0.10
213	PROSTATE NEEDLE AND PUNCH BIOPSY	22	0.01	22	0.00
214	TRANSURETHRAL RESECTION OF PROSTATE & O	37	0.01	37	0.01
235	ARTIFICIAL FERTILIZATION	17	0.00	17	0.00
236	PROCEDURES FOR PREGNANCY AND NEONATAL C	441	0.10	441	0.10
237	TREATMENT OF SPONTANEOUS ABORTION	34	0.01	34	0.01
238	THERAPEUTIC ABORTION	4	0.00	4	0.00
239	VAGINAL DELIVERY	314	0.07	314	0.07
240	FEMALE GENITAL ENDOSCOPY	390	0.09	390	0.09
241	COLPOSCOPY	432	0.10	432	0.10
242	MISCELLANEOUS FEMALE REPRODUCTIVE PROCE	645	0.15	645	0.14
243	DILATION AND CURETTAGE	307	0.07	307	0.07
244	FEMALE GENITAL EXCISION AND REPAIR	73	0.02	73	0.02
261	ELECTROENCEPHALOGRAM	384	0.09	384	0.09
262	ELECTROCONVULSIVE THERAPY	72	0.02	72	0.02
263	NERVE AND MUSCLE TESTS	626	0.15	626	0.14
264	INJECTION OF SUBSTANCE INTO SPINAL CORD	147	0.03	147	0.03
265	SUBDURAL AND SUBARACHNOID TAP	4	0.00	4	0.00
266	NERVE INJECTION AND STIMULATION	120	0.03	120	0.03
267	REVISION AND REMOVAL OF NEUROLOGICAL DE	1	0.00	1	0.00
268	NEUROSTIMULATOR AND VENTRICULAR SHUNT I	5	0.00	5	0.00
269	CARPAL TUNNEL RELEASE	85	0.02	85	0.02
270	NERVE REPAIR AND DESTRUCTION	33	0.01	33	0.01
271	COMPLEX NERVE REPAIR	4	0.00	4	0.00
272	SPINAL TAP	103	0.02	103	0.02
287	MINOR OPHTHALMOLOGICAL TESTS AND PROCED	591	0.14	591	0.13
288	FITTING OF CONTACT LENSES	40	0.01	40	0.01
289	SIMPLE LASER EYE PROCEDURES	47	0.01	47	0.01
290	COMPLEX LASER EYE PROCEDURES	34	0.01	34	0.01
291	CATARACT PROCEDURES	167	0.04	167	0.04
292	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES	2	0.00	2	0.00
293	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES	7	0.00	7	0.00
294	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES	29	0.01	29	0.01
295	MODERATE ANTERIOR SEGMENT EYE PROCEDURE	9	0.00	9	0.00
296	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES	7	0.00	7	0.00
297	SIMPLE POSTERIOR SEGMENT EYE PROCEDURES	12	0.00	12	0.00
298	COMPLEX POSTERIOR SEGMENT EYE PROCEDURE	35	0.01	35	0.01
299	STRABISMUS AND MUSCLE EYE PROCEDURES	33	0.01	33	0.01
300	SIMPLE REPAIR AND PLASTIC PROCEDURES OF	72	0.02	72	0.02
301	COMPLEX REPAIR AND PLASTIC PROCEDURES O	27	0.01	27	0.01
313	OTORHINOLARYNGOLOGIC FUNCTION TESTS	65	0.02	65	0.01
314	MAJOR EXTERNAL EAR PROCEDURES	5	0.00	5	0.00

APG	TITLE	FREQ	PERCENT	ADJUSTED FREQ	ADJUSTED PERCENT
315	TYMPANOSTOMY AND OTHER SIMPLE MIDDLE EA	399	0.09	399	0.09
316	TYMPANOPLASTY AND OTHER COMPLEX MIDDLE	60	0.01	60	0.01
317	INNER EAR PROCEDURES	3	0.00	3	0.00
318	SIMPLE AUDIOMETRY	1501	0.35	1501	0.33
319	REMOVAL OF IMPACTED CERUMEN	130	0.03	130	0.03
341	SIMPLE DIAGNOSTIC NUCLEAR MEDICINE	569	0.13	569	0.13
342	COMPLEX DIAGNOSTIC NUCLEAR MEDICINE	321	0.08	321	0.07
343	THERAPEUTIC NUCLEAR MEDICINE BY INJECTI	20	0.00	20	0.00
344	RADIATION THERAPY	286	0.07	286	0.06
345	OBSTETRICAL ULTRASOUND	1288	0.30	1288	0.29
346	DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICA	1696	0.40	1696	0.38
347	HYPERTHERMIA	.	.	.	.
348	MAGNETIC RESONANCE IMAGING	309	0.07	309	0.07
349	COMPUTERIZED AXIAL TOMOGRAPHY	1590	0.38	1590	0.35
350	MAMMOGRAPHY	1650	0.39	1650	0.37
351	PLAIN FILM	22316	5.28	22316	4.94
352	FLUOROSCOPY	23	0.01	23	0.01
353	CEREBRAL, PULMONARY, CERVICAL AND SPINA	42	0.01	42	0.01
354	VENOGRAPHY OF EXTREMITY	37	0.01	37	0.01
355	NON-CARDIAC, NON-CEREBRAL VASCULAR RADI	60	0.01	60	0.01
356	DIGESTIVE RADIOLOGY	1019	0.24	1019	0.23
357	UROGRAPHY AND GENITAL RADIOLOGY	418	0.10	418	0.09
358	ARTHROGRAPHY	24	0.01	24	0.01
359	MYELOGRAPHY	30	0.01	30	0.01
360	MISCELLANEOUS RADIOLOGY	4	0.00	4	0.00
365	ANESTHESIA	.	.	.	.
391	SIMPLE PATHOLOGY	6700	1.58	6700	1.48
392	COMPLEX PATHOLOGY	41	0.01	41	0.01
417	TISSUE TYPING	101	0.02	101	0.02
418	HUMAN TISSUE CULTURE	5	0.00	5	0.00
419	SIMPLE IMMUNOLOGY TESTS	3525	0.83	3525	0.78
420	COMPLEX IMMUNOLOGY TESTS	784	0.19	784	0.17
421	SIMPLE MICROBIOLOGY TESTS	6007	1.42	6007	1.33
422	COMPLEX MICROBIOLOGY TESTS	635	0.15	635	0.14
423	SIMPLE ENDOCRINOLOGY TESTS	432	0.10	432	0.10
424	COMPLEX ENDOCRINOLOGY TESTS	103	0.02	103	0.02
425	BASIC CHEMISTRY TESTS	5490	1.30	5490	1.22
426	SIMPLE CHEMISTRY TESTS	11556	2.73	11556	2.56
427	COMPLEX CHEMISTRY TESTS	1919	0.45	1919	0.42
428	MULTICHANNEL CHEMISTRY TESTS	5128	1.21	5128	1.14
429	SIMPLE TOXICOLOGY TESTS	60	0.01	60	0.01
430	COMPLEX TOXICOLOGY TESTS	45	0.01	45	0.01
431	URINALYSIS	7791	1.84	7791	1.73
432	THERAPEUTIC DRUG MONITORING	476	0.11	476	0.11
433	RADIOIMMUNOASSAY TESTS	2702	0.64	2702	0.60
434	SIMPLE CLOTTING TESTS	1055	0.25	1055	0.23
435	COMPLEX CLOTTING TESTS	28	0.01	28	0.01
436	SIMPLE HEMATOLOGY TESTS	12408	2.93	12408	2.75

APG	TITLE	FREQ	PERCENT	ADJUSTED FREQ	ADJUSTED PERCENT
437	COMPLEX HEMATOLOGY TESTS	166	0.04	166	0.04
439	LITHIUM LEVEL MONITORING	50	0.01	50	0.01
440	BLOOD AND URINE DIPSTICK TESTS	397	0.09	397	0.09
443	SPIROMETRY AND RESPIRATORY THERAPY	892	0.21	892	0.20
444	INFUSION THERAPY EXCEPT CHEMOTHERAPY	25	0.01	25	0.01
447	CARDIOGRAM	2585	0.61	2585	0.57
449	SIMPLE IMMUNIZATION	2883	0.68	2883	0.64
450	MODERATE IMMUNIZATION	334	0.08	334	0.07
451	COMPLEX IMMUNIZATION	7	0.00	7	0.00
452	MINOR GYNECOLOGICAL PROCEDURES	67	0.02	67	0.01
454	MINOR DOPPLER, ECG MONITORING & AMBULAT	479	0.11	479	0.11
455	MINOR OPHTHALMOLOGICAL INJECTION, SCRAP	101	0.02	101	0.02
456	VESTIBULAR FUNCTION TESTS	69	0.02	69	0.02
457	MINOR URINARY TUBE CHANGE	3	0.00	3	0.00
458	SIMPLE ANOSCOPY	53	0.01	53	0.01
459	BIOFEEDBACK AND HYPNOTHERAPY	18	0.00	18	0.00
460	PROVISION OF VISION AIDS	422	0.10	422	0.09
461	INTRODUCTION OF NEEDLE AND CATHETER	8225	1.94	8225	1.82
469	PROFESSIONAL SERVICE	138276	32.69	138276	30.62
470	INDIVIDUAL PSYCHOTHERAPY	1806	0.43	1806	0.40
471	GROUP PSYCHOTHERAPY	1201	0.28	1201	0.27
472	PSYCHOTROPIC MEDICATION MANAGEMENT	517	0.12	517	0.11
473	COMPREHENSIVE PSYCHIATRIC EVALUATION AN	14915	3.53	14915	3.30
474	FAMILY PSYCHOTHERAPY	2206	0.52	2206	0.49
475	RADIOLOGICAL SUPERVISION AND INTERPRETA	434	0.10	434	0.10
478	THERAPFUTIC RADIOLOGY PLANNING AND DEVI	326	0.08	326	0.07
500	CLASS ONE CHEMOTHERAPY DRUGS	.	.	.	.
501	CLASS TWO CHEMOTHERAPY DRUGS	.	.	.	.
502	CLASS THREE CHEMOTHERAPY DRUGS	.	.	.	.
601	HEMATOLOGICAL MALIGNANCY	1	0.00	357	0.08
602	PROSTATIC MALIGNANCY	.	.	76	0.02
603	LUNG MALIGNANCY	.	.	165	0.04
604	SKIN MALIGNANCY	2	0.00	109	0.02
605	MALIGNANCIES EXCEPT HEMATOLOGICAL, PROS	11	0.00	1151	0.25
616	POISONING	5	0.00	310	0.07
631	HEAD AND SPINE INJURY	.	.	209	0.05
632	BURNS, AND SKIN AND SOFT TISSUE INJURY	36	0.01	2187	0.48
633	FRACTURE, DISLOCATION AND SPRAIN	35	0.01	2717	0.60
634	OTHER INJURIES	1	0.00	168	0.04
654	INDIVIDUAL SUPPORTIVE TREATMENT FOR SEN	.	.	35	0.01
655	PSYCHOTROPIC MEDICATION MANAGEMENT AND	13	0.00	1312	0.29
656	COMPREHENSIVE PSYCHIATRIC EVALUATION AN	.	.	68	0.02
657	COMPREHENSIVE PSYCHIATRIC EVALUATION AN	.	.	32	0.01
658	FAMILY PSYCHOTHERAPY	.	.	13	0.00
659	GROUP PSYCHOTHERAPY	.	.	1	0.00
664	COMPREHENSIVE THERAPY FOR DRUG ABUSE WI	.	.	.	.
667	COMPREHENSIVE THERAPY FOR DRUG ABUSE WI	1	0.00	6	0.00
668	MEDICATION MANAGEMENT AND BRIEF PSYCHOT	1	0.00	72	0.02

APG	TITLE	FREQ	PERCENT	ADJUSTED FREQ	ADJUSTED PERCENT
669	FAMILY THERAPY FOR DRUG ABUSE	.	.	.	.
670	GROUP THERAPY FOR DRUG ABUSE	.	.	.	.
676	NEONATE AND CONGENITAL ANOMALY	.	.	172	0.04
691	ROUTINE PRENATAL CARE	.	.	11	0.00
692	MATERNAL ANTEPARTUM COMPLICATION	1	0.00	23	0.01
693	ROUTINE POSTPARTUM CARE	.	.	3	0.00
694	MATERNAL POSTPARTUM COMPLICATION	.	.	13	0.00
721	SYSTEMIC INFECTIOUS DISEASE	28	0.01	1667	0.37
723	SEXUALLY TRANSMITTED DISEASE IN MALES	.	.	13	0.00
724	SEXUALLY TRANSMITTED DISEASE IN FEMALES	19	0.00	1623	0.36
736	TIA, CVA AND OTHER CEREBROVASCULAR EVEN	.	.	167	0.04
737	HEADACHE	11	0.00	1368	0.30
738	CENTRAL NERVOUS SYSTEM DISEASES EXCEPT	14	0.00	1572	0.35
751	CATARACTS	.	.	110	0.02
752	REFRACTION DISORDER	8	0.00	157	0.03
753	CONJUNCTIVITIS AND OTHER SIMPLE EXTERNA	33	0.01	695	0.15
754	EYE DISEASE EXCEPT CATARACT,REFRACTION	13	0.00	1201	0.27
766	DENTAL DISEASE	5	0.00	121	0.03
767	ACUTE INFECTIOUS EAR, NOSE AND THROAT D	113	0.03	3936	0.87
768	ACUTE INFECTIOUS EAR, NOSE AND THROAT D	264	0.06	10242	2.27
769	ACUTE NONINFECTIOUS EAR, NOSE AND THROA	29	0.01	1622	0.36
771	HEARING LOSS	3	0.00	117	0.03
772	OTHER EAR, NOSE, THROAT AND MOUTH DISEA	28	0.01	1191	0.26
781	EMPHYSEMA, CHRONIC BRONCHITIS AND ASTHM	10	0.00	2282	0.51
782	EMPHYSEMA, CHRONIC BRONCHITIS AND ASTHM	24	0.01	1538	0.34
783	PNEUMONIA	2	0.00	600	0.13
784	RESPIRATORY DISEASE EXCEPT EMPHYSEMA,CH	2	0.00	536	0.12
796	CONGESTIVE HEART FAILURE AND ISCHEMIC H	1	0.00	684	0.15
797	HYPERTENSION	25	0.01	3971	0.88
800	CARDIOVASCULAR DISEASE EXCEPT CHF,ISCHE	15	0.00	2120	0.47
811	NONINFECTIOUS GASTROENTERITIS	13	0.00	1039	0.23
812	ULCERS, GASTRITIS AND ESOPHAGITIS	7	0.00	834	0.18
813	FUNCTIONAL GASTROINTESTINAL DISEASE AND	3	0.00	307	0.07
814	HEPATOBILIARY DISEASE	6	0.00	383	0.08
816	HEMORRHOIDS AND OTHER ANAL-RECTAL DISEA	5	0.00	299	0.07
817	OTHER GASTROINTESTINAL DISEASES	25	0.01	2886	0.64
827	MAJOR SIGNS, SYMPTOMS AND FINDINGS	.	.	145	0.03
841	BACK DISORDERS	10	0.00	1172	0.26
842	MUSCULOSKELETAL DISEASES EXCEPT BACK DI	84	0.02	5423	1.20
856	DISEASE OF NAILS	4	0.00	202	0.04
857	CHRONIC SKIN ULCER	1	0.00	63	0.01
858	CELLULITIS, IMPETIGO AND LYMPHANGITIS	9	0.00	537	0.12
859	BREAST DISEASE	15	0.00	857	0.19
860	OTHER SKIN DISEASES	139	0.03	4894	1.08
871	DIABETES	5	0.00	1621	0.36
872	OBESITY	.	.	60	0.01
873	ENDOCRINE,NUTRITIONAL & METABOLIC DISEA	13	0.00	2244	0.50
886	URINARY TRACT INFECTION	25	0.01	1590	0.35

APG	TITLE	FREQ	PERCENT	ADJUSTED FREQ	ADJUSTED PERCENT
887	RENAL FAILURE	1	0.00	46	0.01
888	URINARY DISEASE EXCEPT URINARY TRACT IN	13	0.00	842	0.19
901	BENIGN PROSTATIC HYPERTROPHY	3	0.00	133	0.03
902	MALE REPRODUCTIVE DISEASES EXCEPT BENIG	11	0.00	407	0.09
916	FEMALE GYNECOLOGIC DISEASE	31	0.01	3601	0.80
932	AIDS RELATED COMPLEX & HIV INFECTION WI	.	.	7	0.00
933	OTHER IMMUNOLOGIC AND HEMATOLOGIC DISEA	9	0.00	817	0.18
946	ADULT MEDICAL EXAMINATION	.	.	148	0.03
947	WELL CHILD CARE	6	0.00	602	0.13
948	COUNSELING	.	.	28	0.01
949	CONTRACEPTION AND PROCREATIVE MANAGEMEN	5	0.00	237	0.05
950	REPEAT PRESCRIPTION	.	.	.	.
951	NONSPECIFIC SIGNS & SYMPTOMS & OTHER CO	24	0.01	3117	0.69
959	ADMITTED OR DIED	5	0.00	10622	2.35
999	UNGROUPABLE	117719	27.83	55654	12.32

APPENDIX J

FINAL AMBULATORY PATIENT GROUP FREQUENCIES

APPENDIX J

Final Ambulatory Patient Group Frequencies

APG	APG TITLE	COUNT	FREQUENCY
1	PHOTOCHEMOTHERAPY	42	0.02
2	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION	73	0.04
3	SIMPLE INCISION AND DRAINAGE	312	0.17
4	COMPLEX INCISION AND DRAINAGE	24	0.01
5	DEBRIDEMENT OF NAILS	59	0.03
6	SIMPLE DEBRIDEMENT AND DESTRUCTION	1357	0.73
7	SIMPLE EXCISION AND BIOPSY	846	0.46
8	COMPLEX EXCISION, BIOPSY AND DEBRIDEMENT	381	0.21
9	LIPECTOMY AND EXCISION WITH RECONSTRUCTI	.	.
10	SIMPLE SKIN REPAIR	366	0.20
11	COMPLEX SKIN REPAIR	72	0.04
12	SKIN AND INTEGUMENT GRAFT, TRANSFER AND	104	0.06
27	SIMPLE INCISION AND EXCISION OF BREAST	120	0.06
28	BREAST RECONSTRUCTION AND MASTECTOMY	46	0.02
53	OCCUPATIONAL THERAPY	70	0.04
54	PHYSICAL THERAPY	2780	1.50
55	DIAGNOSTIC ARTHROSCOPY	31	0.02
56	THERAPEUTIC ARTHROSCOPY	100	0.05
57	REPLACEMENT OF CAST	331	0.18
58	SPLINT, STRAPPING AND CAST REMOVAL	321	0.17
59	TREATMENT OF CLOSED FRACTURE & DISLOCATI	44	0.02
60	TREATMENT OF CLOSED FRACTURE & DISLOCATI	210	0.11
62	TREATMENT OF OPEN FRACTURE AND DISLOCATI	24	0.01
63	JOINT MANIPULATION UNDER ANESTHESIA	12	0.01
64	SIMPLE MAXILLOFACIAL PROCEDURES	82	0.04
65	COMPLEX MAXILLOFACIAL PROCEDURES	99	0.05
66	INCISION OF BONE, JOINT AND TENDON	25	0.01
67	BUNION PROCEDURES	71	0.04
68	EXCISION OF BONE, JOINT AND TENDON OF TH	111	0.06
69	EXCISION OF BONE, JOINT & TENDON EXCEPT	30	0.02
70	ARTHROPLASTY	13	0.01
71	HAND AND FOOT TENOTOMY	2	0.00
72	SIMPLE HAND AND FOOT REPAIR EXCEPT TENOT	61	0.03
73	COMPLEX HAND AND FOOT REPAIR	43	0.02
74	REPAIR,EXCEPT ARTHROTOMY,OF BONE,JOINT,T	56	0.03
75	ARTHROTOMY EXCEPT OF HAND AND FOOT	21	0.01
76	ARTHROCENTESIS AND LIGAMENT OR TENDON IN	770	0.41
77	SPEECH THERAPY	113	0.06
79	PULMONARY TEST AND THERAPY EXCEPT SPIROM	180	0.10
80	NEEDLE AND CATHETER BIOPSY, ASPIRATION,	32	0.02
81	SIMPLE ENDOSCOPY OF THE UPPER AIRWAY	104	0.06
82	COMPLEX ENDOSCOPY OF THE UPPER AIRWAY	24	0.01
83	SIMPLE ENDOSCOPY OF THE LOWER AIRWAY	58	0.03
84	COMPLEX ENDOSCOPY OF THE LOWER AIRWAY	13	0.01

NOTE: APGs flagged for consolidation & ancillary packaging are excluded.

APG	APG TITLE	COUNT	FREQUENCY
85	NASAL CAUTERIZATION AND PACKING	29	0.02
86	SIMPLE LIP, MOUTH AND SALIVARY GLAND PRO	51	0.03
87	COMPLEX LIP, MOUTH AND SALIVARY GLAND PR	32	0.02
88	MISCELLANEOUS SINUS, TRACHEAL AND LUNG P	32	0.02
105	EXERCISE TOLERANCE TESTS	458	0.25
106	ECHOCARDIOGRAPHY	460	0.25
107	PHONOCARDIOGRAM	3	0.00
108	CARDIAC ELECTROPHYSIOLOGIC TESTS	20	0.01
109	VASCULAR CANNULATION WITH NEEDLE AND CAT	152	0.08
110	DIAGNOSTIC CARDIAC CATHETERIZATION	250	0.13
111	ANGIOPLASTY AND TRANSCATHETER PROCEDURES	60	0.03
112	PACEMAKER INSERTION AND REPLACEMENT	5	0.00
113	REMOVAL AND REVISION OF PACEMAKER AND VA	2	0.00
114	MINOR VASCULAR REPAIR AND FISTULA CONSTR	26	0.01
115	SECONDARY VARICOSE VEINS AND VASCULAR IN	43	0.02
116	VASCULAR LIGATION	5	0.00
117	CARDIOPULMONARY RESUSCITATION AND INTUBA	59	0.03
131	CHEMOTHERAPY BY INFUSION	194	0.10
132	CHEMOTHERAPY EXCEPT BY INFUSION	198	0.11
133	TRANSFUSION AND PHLEBOTOMY	75	0.04
134	BLOOD AND BLOOD PRODUCT EXCHANGE	5	0.00
135	DEEP LYMPH STRUCTURE AND THYROID PROCEDU	22	0.01
136	ALLERGY TESTS AND IMMUNOTHERAPY	435	0.23
157	ALIMENTARY TESTS AND SIMPLE TUBE PLACEME	16	0.01
158	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY	5	0.00
159	PERCUTANEOUS AND OTHER SIMPLE GASTROINTE	24	0.01
160	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROC	351	0.19
161	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIO	47	0.03
162	DIAGNOSTIC UPPER GASTROINTESTINAL ENDOSC	305	0.16
163	THERAPEUTIC UPPER GASTROINTESTINAL ENDOS	23	0.01
164	DIAGNOSTIC LOWER GASTROINTESTINAL ENDOSC	216	0.12
165	THERAPEUTIC LOWER GASTROINTESTINAL ENDOS	68	0.04
166	ERCP & OTHER MISCELLANEOUS GASTROINTESTI	19	0.01
167	TONSIL AND ADENOID PROCEDURES	233	0.13
168	HERNIA AND HYDROCELE PROCEDURES	114	0.06
169	SIMPLE HEMORRHOID PROCEDURES	30	0.02
170	SIMPLE ANAL AND RECTAL PROCEDURES EXCEPT	10	0.01
171	COMPLEX ANAL AND RECTAL PROCEDURES	40	0.02
172	PERITONEAL PROCEDURES AND CHANGE OF INTR	18	0.01
173	MISCELLANEOUS DIGESTIVE PROCEDURES	24	0.01
183	SIMPLE URINARY STUDIES AND PROCEDURES	84	0.05
184	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRI	30	0.02
185	URINARY CATHETERIZATION AND DILATATION	150	0.08
186	HEMODIALYSIS	49	0.03
187	PERITONEAL DIALYSIS	4	0.00
188	SIMPLE CYSTOURETHROSCOPY	241	0.13
189	COMPLEX CYSTOURETHROSCOPY AND LITHOLAPAX	77	0.04
190	PERCUTANEOUS RENAL ENDOSCOPY, CATHETERIZ	8	0.00
191	CYSTOTOMY	7	0.00

APG	APG TITLE	COUNT	FREQUENCY
192	SIMPLE URETHRAL PROCEDURES	5	0.00
193	COMPLEX URETHRAL PROCEDURES	6	0.00
209	TESTICULAR AND EPIDIDYMAL PROCEDURES	27	0.01
210	INSERTION OF PENILE PROSTHESIS	2	0.00
211	COMPLEX PENILE PROCEDURES	9	0.00
212	SIMPLE PENILE PROCEDURES	436	0.23
213	PROSTATE NEEDLE AND PUNCH BIOPSY	16	0.01
214	TRANSURETHRAL RESECTION OF PROSTATE & OT	24	0.01
235	ARTIFICIAL FERTILIZATION	16	0.01
236	PROCEDURES FOR PREGNANCY AND NEONATAL CA	408	0.22
237	TREATMENT OF SPONTANEOUS ABORTION	30	0.02
238	THERAPEUTIC ABORTION	4	0.00
239	VAGINAL DELIVERY	295	0.16
240	FEMALE GENITAL ENDOSCOPY	272	0.15
241	COLPOSCOPY	395	0.21
242	MISCELLANEOUS FEMALE REPRODUCTIVE PROCED	495	0.27
243	DILATION AND CURETTAGE	223	0.12
244	FEMALE GENITAL EXCISION AND REPAIR	48	0.03
261	ELECTROENCEPHALOGRAM	342	0.18
262	ELECTROCONVULSIVE THERAPY	63	0.03
263	NERVE AND MUSCLE TESTS	254	0.14
264	INJECTION OF SUBSTANCE INTO SPINAL CORD	129	0.07
265	SUBDURAL AND SUBARACHNOID TAP	3	0.00
266	NERVE INJECTION AND STIMULATION	105	0.06
267	REVISION AND REMOVAL OF NEUROLOGICAL DEV	.	.
268	NEUROSTIMULATOR AND VENTRICULAR SHUNT IM	5	0.00
269	CARPAL TUNNEL RELEASE	40	0.02
270	NERVE REPAIR AND DESTRUCTION	16	0.01
271	COMPLEX NERVE REPAIR	3	0.00
272	SPINAL TAP	83	0.04
287	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDU	525	0.28
288	FITTING OF CONTACT LENSES	39	0.02
289	SIMPLE LASER EYE PROCEDURES	46	0.02
290	COMPLEX LASER EYE PROCEDURES	34	0.02
291	CATARACT PROCEDURES	94	0.05
292	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES F	1	0.00
293	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES	5	0.00
294	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES E	25	0.01
295	MODERATE ANTERIOR SEGMENT EYE PROCEDURES	7	0.00
296	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES	5	0.00
297	SIMPLE POSTERIOR SEGMENT EYE PROCEDURES	7	0.00
298	COMPLEX POSTERIOR SEGMENT EYE PROCEDURES	17	0.01
299	STRABISMUS AND MUSCLE EYE PROCEDURES	17	0.01
300	SIMPLE REPAIR AND PLASTIC PROCEDURES OF	58	0.03
301	COMPLEX REPAIR AND PLASTIC PROCEDURES OF	19	0.01
313	OTORHINOLARYNGOLOGIC FUNCTION TESTS	55	0.03
314	MAJOR EXTERNAL EAR PROCEDURES	3	0.00
315	TYMPANOSTOMY AND OTHER SIMPLE MIDDLE EAR	283	0.15
316	TYMPANOPLASTY AND OTHER COMPLEX MIDDLE E	32	0.02

APG	APG TITLE	COUNT	FREQUENCY
317	INNER EAR PROCEDURES	2	0.00
318	SIMPLE AUDIOMETRY	1013	0.55
319	REMOVAL OF IMPACTED CERUMEN	128	0.07
341	SIMPLE DIAGNOSTIC NUCLEAR MEDICINE	528	0.28
342	COMPLEX DIAGNOSTIC NUCLEAR MEDICINE	294	0.16
343	THERAPEUTIC NUCLEAR MEDICINE BY INJECTIO	19	0.01
344	RADIATION THERAPY	256	0.14
345	OBSTETRICAL ULTRASOUND	1085	0.58
346	DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL	1574	0.85
347	HYPERTHERMIA	.	.
348	MAGNETIC RESONANCE IMAGING	395	0.21
349	COMPUTERIZED AXIAL TOMOGRAPHY	1441	0.78
350	MAMMOGRAPHY	1589	0.86
351	PLAIN FILM	7457	4.02
352	FLUOROSCOPY	20	0.01
353	CEREBRAL, PULMONARY, CERVICAL AND SPINAL	35	0.02
354	VENOGRAPHY OF EXTREMITY	37	0.02
355	NON-CARDIAC, NON-CEREBRAL VASCULAR RADIO	52	0.03
356	DIGESTIVE RADIOLOGY	968	0.52
357	UROGRAPHY AND GENITAL RADIOLOGY	378	0.20
358	ARTHROGRAPHY	24	0.01
359	MYELOGRAPHY	28	0.02
360	MISCELLANEOUS RADIOLOGY	4	0.00
365	ANESTHESIA	.	.
391	SIMPLE PATHOLOGY	1902	1.02
392	COMPLEX PATHOLOGY	32	0.02
417	TISSUE TYPING	55	0.03
418	HUMAN TISSUE CULTURE	5	0.00
419	SIMPLE IMMUNOLOGY TESTS	910	0.49
420	COMPLEX IMMUNOLOGY TESTS	582	0.31
421	SIMPLE MICROBIOLOGY TESTS	1325	0.71
422	COMPLEX MICROBIOLOGY TESTS	502	0.27
423	SIMPLE ENDOCRINOLOGY TESTS	115	0.06
424	COMPLEX ENDOCRINOLOGY TESTS	87	0.05
425	BASIC CHEMISTRY TESTS	1727	0.93
426	SIMPLE CHEMISTRY TESTS	3241	1.75
427	COMPLEX CHEMISTRY TESTS	1429	0.77
428	MULTICHANNEL CHEMISTRY TESTS	1415	0.76
429	SIMPLE TOXICOLOGY TESTS	32	0.02
430	COMPLEX TOXICOLOGY TESTS	23	0.01
431	URINALYSIS	1121	0.60
432	THERAPEUTIC DRUG MONITORING	408	0.22
433	RADIOIMMUNOASSAY TESTS	1854	1.00
434	SIMPLE CLOTTING TESTS	433	0.23
435	COMPLEX CLOTTING TESTS	15	0.01
436	SIMPLE HEMATOLOGY TESTS	2655	1.43
437	COMPLEX HEMATOLOGY TESTS	103	0.06
439	LITHIUM LEVEL MONITORING	33	0.02
440	BLOOD AND URINE DIPSTICK TESTS	105	0.06

APG	APG TITLE	COUNT	FREQUENCY
443	SPIROMETRY AND RESPIRATORY THERAPY	.	.
444	INFUSION THERAPY EXCEPT CHEMOTHERAPY	23	0.01
447	CARDIOGRAM	.	.
449	SIMPLE IMMUNIZATION	295	0.16
450	MODERATE IMMUNIZATION	86	0.05
451	COMPLEX IMMUNIZATION	7	0.00
452	MINOR GYNECOLOGICAL PROCEDURES	27	0.01
454	MINOR DOPPLER, ECG MONITORING & AMBULATO	.	.
455	MINOR OPHTHALMOLOGICAL INJECTION, SCRAPI	.	.
456	VESTIBULAR FUNCTION TESTS	.	.
457	MINOR URINARY TUBE CHANGE	.	.
458	SIMPLE ANOSCOPY	8	0.00
459	BIOFEEDBACK AND HYPNOTHERAPY	.	.
460	PROVISION OF VISION AIDS	.	.
461	INTRODUCTION OF NEEDLE AND CATHETER	898	0.48
469	PROFESSIONAL SERVICE	.	.
470	INDIVIDUAL PSYCHOTHERAPY	.	.
471	GROUP PSYCHOTHERAPY	.	.
472	PSYCHOTROPIC MEDICATION MANAGEMENT	.	.
473	COMPREHENSIVE PSYCHIATRIC EVALUATION AND	.	.
474	FAMILY PSYCHOTHERAPY	.	.
475	RADIOLOGICAL SUPERVISION AND INTERPRETAT	.	.
478	THERAPEUTIC RADIOLOGY PLANNING AND DEVIC	.	.
500	CLASS ONE CHEMOTHERAPY DRUGS	.	.
501	CLASS TWO CHEMOTHERAPY DRUGS	.	.
502	CLASS THREE CHEMOTHERAPY DRUGS	.	.
601	HEMATOLOGICAL MALIGNANCY	337	0.18
602	PROSTATIC MALIGNANCY	84	0.05
603	LUNG MALIGNANCY	274	0.15
604	SKIN MALIGNANCY	120	0.06
605	MALIGNANCIES EXCEPT HEMATOLOGICAL, PROST	1406	0.76
616	POISONING	382	0.21
631	HEAD AND SPINE INJURY	227	0.12
632	BURNS, AND SKIN AND SOFT TISSUE INJURY	2282	1.23
633	FRACTURE, DISLOCATION AND SPRAIN	2934	1.58
634	OTHER INJURIES	197	0.11
654	INDIVIDUAL SUPPORTIVE TREATMENT FOR SENI	100	0.05
655	PSYCHOTROPIC MEDICATION MANAGEMENT AND B	3664	1.97
656	COMPREHENSIVE PSYCHIATRIC EVALUATION AND	8104	4.37
657	COMPREHENSIVE PSYCHIATRIC EVALUATION AND	4377	2.36
658	FAMILY PSYCHOTHERAPY	1930	1.04
659	GROUP PSYCHOTHERAPY	752	0.41
664	COMPREHENSIVE THERAPY FOR DRUG ABUSE WIT	33	0.02
667	COMPREHENSIVE THERAPY FOR DRUG ABUSE WIT	250	0.13
668	MEDICATION MANAGEMENT AND BRIEF PSYCHOTH	131	0.07
669	FAMILY THERAPY FOR DRUG ABUSE	26	0.01
670	GROUP THERAPY FOR DRUG ABUSE	63	0.03
676	NEONATE AND CONGENITAL ANOMALY	417	0.22
691	ROUTINE PRENATAL CARE	11	0.01

APG	APG TITLE	COUNT	FREQUENCY
692	MATERNAL ANTEPARTUM COMPLICATION	47	0.03
693	ROUTINE POSTPARTUM CARE	5	0.00
694	MATERNAL POSTPARTUM COMPLICATION	18	0.01
721	SYSTEMIC INFECTIOUS DISEASE	1751	0.94
723	SEXUALLY TRANSMITTED DISEASE IN MALES	13	0.01
724	SEXUALLY TRANSMITTED DISEASE IN FEMALES	1635	0.88
736	TIA, CVA AND OTHER CEREBROVASCULAR EVENT	284	0.15
737	HEADACHE	1507	0.81
738	CENTRAL NERVOUS SYSTEM DISEASES EXCEPT T	2129	1.15
751	CATARACTS	246	0.13
752	REFRACTION DISORDER	884	0.48
753	CONJUNCTIVITIS AND OTHER SIMPLE EXTERNAL	829	0.45
754	EYE DISEASE EXCEPT CATARACT,REFRACTION D	2033	1.10
766	DENTAL DISEASE	128	0.07
767	ACUTE INFECTIOUS EAR, NOSE AND THROAT DI	4063	2.19
768	ACUTE INFECTIOUS EAR, NOSE AND THROAT DI	10515	5.67
769	ACUTE NONINFECTIOUS EAR, NOSE AND THROAT	4089	2.20
771	HEARING LOSS	142	0.08
772	OTHER EAR, NOSE, THROAT AND MOUTH DISEAS	1285	0.69
781	EMPHYSEMA, CHRONIC BRONCHITIS AND ASTHMA	2674	1.44
782	EMPHYSEMA, CHRONIC BRONCHITIS AND ASTHMA	1769	0.95
783	PNEUMONIA	623	0.34
784	RESPIRATORY DISEASE EXCEPT EMPHYSEMA,CHR	751	0.40
796	CONGESTIVE HEART FAILURE AND ISCHEMIC HE	972	0.52
797	HYPERTENSION	4140	2.23
800	CARDIOVASCULAR DISEASE EXCEPT CHF,ISCHEM	2656	1.43
811	NONINFECTIOUS GASTROENTERITIS	1067	0.57
812	ULCERS, GASTRITIS AND ESOPHAGITIS	855	0.46
813	FUNCTIONAL GASTROINTESTINAL DISEASE AND	321	0.17
814	HEPATOBILIARY DISEASE	395	0.21
816	HEMORRHOIDS AND OTHER ANAL-RECTAL DISEAS	319	0.17
817	OTHER GASTROINTESTINAL DISEASES	3047	1.64
827	MAJOR SIGNS, SYMPTOMS AND FINDINGS	248	0.13
841	BACK DISORDERS	1305	0.70
842	MUSCULOSKELETAL DISEASES EXCEPT BACK DIS	6023	3.25
856	DISEASE OF NAILS	213	0.11
857	CHRONIC SKIN ULCER	74	0.04
858	CELLULITIS, IMPETIGO AND LYMPHANGITIS	564	0.30
859	BREAST DISEASE	894	0.48
860	OTHER SKIN DISEASES	5584	3.01
871	DIABETES	2084	1.12
872	OBESITY	66	0.04
873	ENDOCRINE,NUTRITIONAL & METABOLIC DISEAS	2458	1.32
886	URINARY TRACT INFECTION	1620	0.87
887	RENAL FAILURE	95	0.05
888	URINARY DISEASE EXCEPT URINARY TRACT INF	917	0.49
901	BENIGN PROSTATIC HYPERTROPHY	136	0.07
902	MALE REPRODUCTIVE DISEASES EXCEPT BENIGN	420	0.23
916	FEMALE GYNECOLOGIC DISEASE	3906	2.10

APG	APG TITLE	COUNT	FREQUENCY
932	AIDS RELATED COMPLEX & HIV INFECTION WIT	7	0.00
933	OTHER IMMUNOLOGIC AND HEMATOLOGIC DISEAS	940	0.51
946	ADULT MEDICAL EXAMINATION	178	0.10
947	WELL CHILD CARE	2504	1.35
948	COUNSELING	52	0.03
949	CONTRACEPTION AND PROCREATIVE MANAGEMENT	246	0.13
950	REPEAT PRESCRIPTION	9	0.00
951	NONSPECIFIC SIGNS & SYMPTOMS & OTHER CON	3716	2.00
959	ADMITTED OR DIED	13796	7.43

APPENDIX K

AMBULATORY PATIENT GROUP STATISTICS AFTER CONSOLIDATION/PACKAGING, TRIMMED DATA

APPENDIX K

Ambulatory Patient Group Statistics
After Consolidation/Packaging, Trimmed Data

APG	APG TITLE	COUNT	MEAN	CV
1	PHOTOCHEMOTHERAPY	34	37.81	0.58
2	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION	71	108.51	0.77
3	SIMPLE INCISION AND DRAINAGE	301	60.64	0.63
4	COMPLEX INCISION AND DRAINAGE	25	155.14	0.83
5	DEBRIDEMENT OF NAILS	32	48.27	0.51
6	SIMPLE DEBRIDEMENT AND DESTRUCTION	1314	62.21	0.66
7	SIMPLE EXCISION AND BIOPSY	853	155.89	0.62
8	COMPLEX EXCISION, BIOPSY AND DEBRIDEMENT	390	305.00	0.78
9	LIPECTOMY AND EXCISION WITH RECONSTRUCTI	.	.	.
10	SIMPLE SKIN REPAIR	370	147.45	0.56
11	COMPLEX SKIN REPAIR	79	511.64	0.59
12	SKIN AND INTEGUMENT GRAFT, TRANSFER AND	104	888.66	0.79
27	SIMPLE INCISION AND EXCISION OF BREAST	156	611.81	0.58
28	BREAST RECONSTRUCTION AND MASTECTOMY	50	1517.96	0.81
53	OCCUPATIONAL THERAPY	68	60.24	0.74
54	PHYSICAL THERAPY	2599	64.97	1.00
55	DIAGNOSTIC ARTHROSCOPY	31	470.06	0.85
56	THERAPEUTIC ARTHROSCOPY	109	1797.21	0.62
57	REPLACEMENT OF CAST	331	136.49	0.44
58	SPLINT, STRAPPING AND CAST REMOVAL	313	88.72	0.75
59	TREATMENT OF CLOSED FRACTURE & DISLOCATI	45	166.53	0.63
60	TREATMENT OF CLOSED FRACTURE & DISLOCATI	226	398.31	0.57
62	TREATMENT OF OPEN FRACTURE AND DISLOCATI	29	927.12	0.84
63	JOINT MANIPULATION UNDER ANESTHESIA	11	384.91	0.67
64	SIMPLE MAXILLOFACIAL PROCEDURES	84	248.98	1.12
65	COMPLEX MAXILLOFACIAL PROCEDURES	106	1562.06	0.68
66	INCISION OF BONE, JOINT AND TENDON	26	300.52	0.97
67	BUNION PROCEDURES	81	1006.60	0.56
68	EXCISION OF BONE, JOINT AND TENDON OF TH	134	605.14	0.58
69	EXCISION OF BONE, JOINT & TENDON EXCEPT	32	726.78	0.80
70	ARTHROPLASTY	13	1490.67	0.75
71	HAND AND FOOT TENOTOMY	2	145.50	0.10
72	SIMPLE HAND AND FOOT REPAIR EXCEPT TENOT	73	680.94	0.80
73	COMPLEX HAND AND FOOT REPAIR	46	811.53	0.72
74	REPAIR,EXCEPT ARTHROTOMY,OF BONE,JOINT,T	57	1175.10	0.71
75	ARTHROTOMY EXCEPT OF HAND AND FOOT	22	1254.49	0.66
76	ARTHROCENTESIS AND LIGAMENT OR TENDON IN	753	85.79	0.49
77	SPEECH THERAPY	106	30.28	0.62
79	PULMONARY TEST AND THERAPY EXCEPT SPIROM	189	122.54	0.80
80	NEEDLE AND CATHETER BIOPSY, ASPIRATION,	38	241.44	0.56
81	SIMPLE ENDOSCOPY OF THE UPPER AIRWAY	100	182.57	0.61
82	COMPLEX ENDOSCOPY OF THE UPPER AIRWAY	25	910.26	0.75
83	SIMPLE ENDOSCOPY OF THE LOWER AIRWAY	66	569.26	0.43

APG	APG TITLE	COUNT	MEAN	CV
84	COMPLEX ENDOSCOPY OF THE LOWER AIRWAY	15	463.41	0.19
85	NASAL CAUTERIZATION AND PACKING	28	144.05	0.86
86	SIMPLE LIP, MOUTH AND SALIVARY GLAND PRO	45	190.24	0.88
87	COMPLEX LIP, MOUTH AND SALIVARY GLAND PR	32	1259.31	0.85
88	MISCELLANEOUS SINUS, TRACHEAL AND LUNG P	33	765.15	0.76
105	EXERCISE TOLERANCE TESTS	461	241.73	0.49
106	ECHOCARDIOGRAPHY	476	307.85	0.57
107	PHONOCARDIOGRAM	3	196.25	0.96
108	CARDIAC ELECTROPHYSIOLOGIC TESTS	22	487.71	1.19
109	VASCULAR CANNULATION WITH NEEDLE AND CAT	183	299.11	0.78
110	DIAGNOSTIC CARDIAC CATHETERIZATION	264	1053.39	0.36
111	ANGIOPLASTY AND TRANSCATHETER PROCEDURES	63	1944.17	0.43
112	PACEMAKER INSERTION AND REPLACEMENT	5	1403.38	0.42
113	REMOVAL AND REVISION OF PACEMAKER AND VA	3	247.33	0.67
114	MINOR VASCULAR REPAIR AND FISTULA CONSTR	24	947.77	0.59
115	SECONDARY VARICOSE VEINS AND VASCULAR IN	31	194.08	1.25
116	VASCULAR LIGATION	5	1543.27	0.91
117	CARDIOPULMONARY RESUSCITATION AND INTUBA	77	280.24	0.79
131	CHEMOTHERAPY BY INFUSION	222	156.57	0.73
132	CHEMOTHERAPY EXCEPT BY INFUSION	221	116.06	0.61
133	TRANSFUSION AND PHLEBOTOMY	80	156.74	1.25
134	BLOOD AND BLOOD PRODUCT EXCHANGE	6	467.20	0.52
135	DEEP LYMPH STRUCTURE AND THYROID PROCEDU	25	839.93	0.68
136	ALLERGY TESTS AND IMMUNOTHERAPY	420	80.63	0.86
157	ALIMENTARY TESTS AND SIMPLE TUBE PLACEME	14	308.48	0.84
158	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY	6	104.44	0.34
159	PERCUTANEOUS AND OTHER SIMPLE GASTROINTE	26	217.06	0.70
160	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROC	377	149.26	0.48
161	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIO	49	287.73	0.65
162	DIAGNOSTIC UPPER GASTROINTESTINAL ENDOSC	314	455.39	0.42
163	THERAPEUTIC UPPER GASTROINTESTINAL ENDOS	24	651.67	0.34
164	DIAGNOSTIC LOWER GASTROINTESTINAL ENDOSC	224	646.90	0.38
165	THERAPEUTIC LOWER GASTROINTESTINAL ENDOS	71	1008.25	0.26
166	ERCP & OTHER MISCELLANEOUS GASTROINTESTI	21	549.87	0.61
167	TONSIL AND ADENOID PROCEDURES	241	548.70	0.54
168	HERNIA AND HYDROCELE PROCEDURES	126	932.75	0.60
169	SIMPLE HEMORRHOID PROCEDURES	31	189.93	0.70
170	SIMPLE ANAL AND RECTAL PROCEDURES EXCEPT	12	512.33	0.98
171	COMPLEX ANAL AND RECTAL PROCEDURES	39	784.78	0.51
172	PERITONEAL PROCEDURES AND CHANGE OF INTR	20	310.61	0.98
173	MISCELLANEOUS DIGESTIVE PROCEDURES	20	680.76	0.81
183	SIMPLE URINARY STUDIES AND PROCEDURES	90	125.83	0.71
184	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRI	34	2255.33	0.94
185	URINARY CATHETERIZATION AND DILATATION	156	81.75	0.77
186	HEMODIALYSIS	47	257.24	0.67
187	PERITONEAL DIALYSIS	4	222.36	0.72
188	SIMPLE CYSTOURETHROSCOPY	265	287.95	0.68
189	COMPLEX CYSTOURETHROSCOPY AND LITHOLAPAX	87	643.10	0.75
190	PERCUTANEOUS RENAL ENDOSCOPY, CATHETERIZ	7	352.83	0.44

APG	APG TITLE	COUNT	MEAN	CV
191	CYSTOTOMY	7	436.59	0.53
192	SIMPLE URETHRAL PROCEDURES	3	125.43	0.14
193	COMPLEX URETHRAL PROCEDURES	7	829.09	0.81
209	TESTICULAR AND EPIDIDYMAL PROCEDURES	28	468.14	0.85
210	INSERTION OF PENILE PROSTHESIS	.	.	.
211	COMPLEX PENILE PROCEDURES	9	667.84	1.01
212	SIMPLE PENILE PROCEDURES	407	121.92	1.39
213	PROSTATE NEEDLE AND PUNCH BIOPSY	19	315.80	0.77
214	TRANSURETHRAL RESECTION OF PROSTATE & OT	25	1329.40	0.54
235	ARTIFICIAL FERTILIZATION	.	.	.
236	PROCEDURES FOR PREGNANCY AND NEONATAL CA	355	151.10	1.11
237	TREATMENT OF SPONTANEOUS ABORTION	30	434.63	0.57
238	THERAPEUTIC ABORTION	3	488.33	0.63
239	VAGINAL DELIVERY	288	856.63	0.60
240	FEMALE GENITAL ENDOSCOPY	283	776.69	0.57
241	COLPOSCOPY	382	199.66	0.65
242	MISCELLANEOUS FEMALE REPRODUCTIVE PROCED	485	193.11	0.97
243	DILATION AND CURETTAGE	239	461.44	0.63
244	FEMALE GENITAL EXCISION AND REPAIR	54	680.35	0.87
261	ELECTROENCEPHALOGRAM	339	156.53	0.69
262	ELECTROCONVULSIVE THERAPY	61	153.91	0.77
263	NERVE AND MUSCLE TESTS	249	201.17	0.55
264	INJECTION OF SUBSTANCE INTO SPINAL CORD	118	379.72	0.99
265	SUBDURAL AND SUBARACHNOID TAP	4	632.00	0.61
266	NERVE INJECTION AND STIMULATION	84	108.26	0.88
267	REVISION AND REMOVAL OF NEUROLOGICAL DEV	.	.	.
268	NEUROSTIMULATOR AND VENTRICULAR SHUNT IM	.	.	.
269	CARPAL TUNNEL RELEASE	53	1084.16	0.61
270	NERVE REPAIR AND DESTRUCTION	19	1152.99	0.69
271	COMPLEX NERVE REPAIR	3	1379.15	0.71
272	SPINAL TAP	95	158.80	0.69
287	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDU	162	163.98	0.68
288	FITTING OF CONTACT LENSES	8	109.03	0.70
289	SIMPLE LASER EYE PROCEDURES	43	810.53	0.24
290	COMPLEX LASER EYE PROCEDURES	32	983.30	0.28
291	CATARACT PROCEDURES	110	2426.12	0.58
292	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES F	.	.	.
293	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES	6	425.71	1.96
294	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES E	25	126.87	1.00
295	MODERATE ANTERIOR SEGMENT EYE PROCEDURES	7	1192.94	0.86
296	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES	6	2328.03	0.68
297	SIMPLE POSTERIOR SEGMENT EYE PROCEDURES	8	745.09	0.78
298	COMPLEX POSTERIOR SEGMENT EYE PROCEDURES	19	2216.87	0.78
299	STRABISMUS AND MUSCLE EYE PROCEDURES	18	1575.35	0.48
300	SIMPLE REPAIR AND PLASTIC PROCEDURES OF	57	146.37	0.85
301	COMPLEX REPAIR AND PLASTIC PROCEDURES OF	19	1047.76	0.87
313	OTORHINOLARYNGOLOGIC FUNCTION TESTS	59	169.65	0.57
314	MAJOR EXTERNAL EAR PROCEDURES	4	640.50	1.44
315	TYMPANOSTOMY AND OTHER SIMPLE MIDDLE EAR	288	378.07	0.65

APG	APG TITLE	COUNT	MEAN	CV
316	TYMPANOPLASTY AND OTHER COMPLEX MIDDLE E	36	1922.63	0.65
317	INNER EAR PROCEDURES	2	2046.50	0.10
318	SIMPLE AUDIOMETRY	975	72.11	0.66
319	REMOVAL OF IMPACTED CERUMEN	92	41.95	0.61
341	SIMPLE DIAGNOSTIC NUCLEAR MEDICINE	527	93.98	0.54
342	COMPLEX DIAGNOSTIC NUCLEAR MEDICINE	291	193.76	0.69
343	THERAPEUTIC NUCLEAR MEDICINE BY INJECTIO	20	142.33	0.88
344	RADIATION THERAPY	251	258.55	1.17
345	OBSTETRICAL ULTRASOUND	991	109.03	0.42
346	DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL	1535	102.06	0.51
347	HYPERTHERMIA	.	.	.
348	MAGNETIC RESONANCE IMAGING	375	469.11	0.65
349	COMPUTERIZED AXIAL TOMOGRAPHY	1507	201.05	0.70
350	MAMMOGRAPHY	1484	67.08	0.48
351	PLAIN FILM	7601	65.61	1.25
352	FLUOROSCOPY	23	83.77	1.07
353	CEREBRAL, PULMONARY, CERVICAL AND SPINAL	39	427.12	0.45
354	VENOGRAPHY OF EXTREMITY	35	143.07	0.51
355	NON-CARDIAC, NON-CEREBRAL VASCULAR RADIO	53	386.28	0.53
356	DIGESTIVE RADIOLOGY	990	79.54	0.53
357	UROGRAPHY AND GENITAL RADIOLOGY	395	82.38	0.59
358	ARTHROGRAPHY	24	127.19	0.45
359	MYELOGRAPHY	29	250.21	0.29
360	MISCELLANEOUS RADIOLOGY	4	98.58	0.26
365	ANESTHESIA	.	.	.
391	SIMPLE PATHOLOGY	1919	46.46	0.85
392	COMPLEX PATHOLOGY	34	302.13	0.70
417	TISSUE TYPING	99	20.52	1.61
418	HUMAN TISSUE CULTURE	4	109.50	0.94
419	SIMPLE IMMUNOLOGY TESTS	1402	13.21	0.68
420	COMPLEX IMMUNOLOGY TESTS	727	23.80	0.61
421	SIMPLE MICROBIOLOGY TESTS	1504	16.73	0.48
422	COMPLEX MICROBIOLOGY TESTS	581	21.79	0.62
423	SIMPLE ENDOCRINOLOGY TESTS	177	26.70	0.63
424	COMPLEX ENDOCRINOLOGY TESTS	96	48.35	0.45
425	BASIC CHEMISTRY TESTS	2220	11.38	0.51
426	SIMPLE CHEMISTRY TESTS	3584	35.99	1.04
427	COMPLEX CHEMISTRY TESTS	1775	22.39	0.56
428	MULTICHANNEL CHEMISTRY TESTS	1739	24.09	0.58
429	SIMPLE TOXICOLOGY TESTS	41	33.46	0.39
430	COMPLEX TOXICOLOGY TESTS	37	26.19	0.76
431	URINALYSIS	1486	8.22	0.38
432	THERAPEUTIC DRUG MONITORING	447	32.27	0.37
433	RADIOIMMUNOASSAY TESTS	2550	33.48	0.50
434	SIMPLE CLOTTING TESTS	531	10.40	0.43
435	COMPLEX CLOTTING TESTS	28	18.14	0.76
436	SIMPLE HEMATOLOGY TESTS	3403	11.54	0.48
437	COMPLEX HEMATOLOGY TESTS	144	58.50	0.67
439	LITHIUM LEVEL MONITORING	32	17.15	0.25

APG	APG TITLE	COUNT	MEAN	CV
440	BLOOD AND URINE DIPSTICK TESTS	114	9.49	0.34
443	SPIROMETRY AND RESPIRATORY THERAPY	.	.	.
444	INFUSION THERAPY EXCEPT CHEMOTHERAPY	21	64.52	0.94
447	CARDIOGRAM	.	.	.
449	SIMPLE IMMUNIZATION	186	18.94	0.52
450	MODERATE IMMUNIZATION	75	34.18	0.61
451	COMPLEX IMMUNIZATION	6	34.17	0.90
452	MINOR GYNECOLOGICAL PROCEDURES	27	71.49	0.77
454	MINOR DOPPLER, ECG MONITORING & AMBULATO	.	.	.
455	MINOR OPHTHALMOLOGICAL INJECTION, SCRAPI	.	.	.
456	VESTIBULAR FUNCTION TESTS	.	.	.
457	MINOR URINARY TUBE CHANGE	.	.	.
458	SIMPLE ANOSCOPY	8	41.06	0.38
459	BIOFEEDBACK AND HYPNOTHERAPY	.	.	.
460	PROVISION OF VISION AIDS	.	.	.
461	INTRODUCTION OF NEEDLE AND CATHETER	678	15.25	2.41
469	PROFESSIONAL SERVICE	.	.	.
470	INDIVIDUAL PSYCHOTHERAPY	.	.	.
471	GROUP PSYCHOTHERAPY	.	.	.
472	PSYCHOTROPIC MEDICATION MANAGEMENT	.	.	.
473	COMPREHENSIVE PSYCHIATRIC EVALUATION AND	.	.	.
474	FAMILY PSYCHOTHERAPY	.	.	.
475	RADIOLOGICAL SUPERVISION AND INTERPRETAT	.	.	.
478	THERAPEUTIC RADIOLOGY PLANNING AND DEVIC	.	.	.
500	CLASS ONE CHEMOTHERAPY DRUGS	.	.	.
501	CLASS TWO CHEMOTHERAPY DRUGS	.	.	.
502	CLASS THREE CHEMOTHERAPY DRUGS	.	.	.
601	HEMATOLOGICAL MALIGNANCY	367	92.13	1.14
602	PROSTATIC MALIGNANCY	88	88.54	1.34
603	LUNG MALIGNANCY	275	123.71	1.24
604	SKIN MALIGNANCY	127	72.41	1.41
605	MALIGNANCIES EXCEPT HEMATOLOGICAL, PROST	1428	104.63	1.74
616	POISONING	388	86.23	1.05
631	HEAD AND SPINE INJURY	238	128.33	1.02
632	BURNS, AND SKIN AND SOFT TISSUE INJURY	2265	89.15	0.88
633	FRACTURE, DISLOCATION AND SPRAIN	2942	89.55	0.94
634	OTHER INJURIES	192	71.64	0.90
654	INDIVIDUAL SUPPORTIVE TREATMENT FOR SENI	92	72.51	0.49
655	PSYCHOTROPIC MEDICATION MANAGEMENT AND B	3483	52.20	0.63
656	COMPREHENSIVE PSYCHIATRIC EVALUATION AND	7839	80.14	0.22
657	COMPREHENSIVE PSYCHIATRIC EVALUATION AND	4253	79.87	0.25
658	FAMILY PSYCHOTHERAPY	1881	89.15	0.35
659	GROUP PSYCHOTHERAPY	719	44.02	0.36
664	COMPREHENSIVE THERAPY FOR DRUG ABUSE WIT	31	75.79	0.09
667	COMPREHENSIVE THERAPY FOR DRUG ABUSE WIT	241	75.80	0.30
668	MEDICATION MANAGEMENT AND BRIEF PSYCHOTH	109	132.79	1.16
669	FAMILY THERAPY FOR DRUG ABUSE	20	63.28	0.24
670	GROUP THERAPY FOR DRUG ABUSE	56	45.83	0.67
676	NEONATE AND CONGENITAL ANOMALY	387	79.83	1.16

APG	APG TITLE	COUNT	MEAN	CV
691	ROUTINE PRENATAL CARE	9	65.68	0.62
692	MATERNAL ANTEPARTUM COMPLICATION	45	85.63	0.75
693	ROUTINE POSTPARTUM CARE	5	41.16	0.35
694	MATERNAL POSTPARTUM COMPLICATION	19	41.32	0.71
721	SYSTEMIC INFECTIOUS DISEASE	1776	59.77	1.14
723	SEXUALLY TRANSMITTED DISEASE IN MALES	13	46.56	0.67
724	SEXUALLY TRANSMITTED DISEASE IN FEMALES	1612	56.70	0.64
736	TIA, CVA AND OTHER CEREBROVASCULAR EVENT	268	116.39	1.35
737	HEADACHE	1461	60.29	0.88
738	CENTRAL NERVOUS SYSTEM DISEASES EXCEPT T	2082	94.51	1.27
751	CATARACTS	248	80.97	1.66
752	REFRACTION DISORDER	828	44.33	0.44
753	CONJUNCTIVITIS AND OTHER SIMPLE EXTERNAL	802	36.86	0.53
754	EYE DISEASE EXCEPT CATARACT,REFRACTION D	1982	51.69	0.79
766	DENTAL DISEASE	122	59.45	0.82
767	ACUTE INFECTIOUS EAR, NOSE AND THROAT DI	4006	44.39	0.74
768	ACUTE INFECTIOUS EAR, NOSE AND THROAT DI	10351	38.66	0.65
769	ACUTE NONINFECTIOUS EAR, NOSE AND THROAT	3945	23.97	0.94
771	HEARING LOSS	140	60.39	1.44
772	OTHER EAR, NOSE, THROAT AND MOUTH DISEAS	1268	39.39	0.80
781	EMPHYSEMA, CHRONIC BRONCHITIS AND ASTHMA	2680	66.64	1.08
782	EMPHYSEMA, CHRONIC BRONCHITIS AND ASTHMA	1745	48.78	1.01
783	PNEUMONIA	617	76.44	0.92
784	RESPIRATORY DISEASE EXCEPT EMPHYSEMA,CHR	766	114.00	1.08
796	CONGESTIVE HEART FAILURE AND ISCHEMIC HE	989	90.66	1.29
797	HYPERTENSION	4060	43.81	0.71
800	CARDIOVASCULAR DISEASE EXCEPT CHF,ISCHEM	2668	90.11	1.21
811	NONINFECTIOUS GASTROENTERITIS	1054	59.61	0.96
812	ULCERS, GASTRITIS AND ESOPHAGITIS	856	67.27	1.16
813	FUNCTIONAL GASTROINTESTINAL DISEASE AND	312	51.50	0.80
814	HEPATOBILIARY DISEASE	405	64.20	0.94
816	HEMORRHOIDS AND OTHER ANAL-RECTAL DISEAS	320	58.08	0.92
817	OTHER GASTROINTESTINAL DISEASES	3104	76.76	1.09
827	MAJOR SIGNS, SYMPTOMS AND FINDINGS	178	171.30	1.25
841	BACK DISORDERS	1269	68.43	0.98
842	MUSCULOSKELETAL DISEASES EXCEPT BACK DIS	5994	62.50	0.97
856	DISEASE OF NAILS	205	33.32	0.50
857	CHRONIC SKIN ULCER	69	40.71	0.69
858	CELLULITIS, IMPETIGO AND LYMPHANGITIS	561	43.81	0.71
859	BREAST DISEASE	900	58.82	1.06
860	OTHER SKIN DISEASES	5431	36.86	0.67
871	DIABETES	2035	47.68	0.89
872	OBESITY	54	53.42	0.88
873	ENDOCRINE,NUTRITIONAL & METABOLIC DISEAS	2422	50.50	0.87
886	URINARY TRACT INFECTION	1619	59.03	0.80
887	RENAL FAILURE	95	135.15	1.41
888	URINARY DISEASE EXCEPT URINARY TRACT INF	944	86.89	1.20
901	BENIGN PROSTATIC HYPERTROPHY	139	56.59	0.92
902	MALE REPRODUCTIVE DISEASES EXCEPT BENIGN	408	49.54	0.80

APG	APG TITLE	COUNT	MEAN	CV
916	FEMALE GYNECOLOGIC DISEASE	3871	56.48	0.86
932	AIDS RELATED COMPLEX & HIV INFECTION WIT	7	56.03	0.27
933	OTHER IMMUNOLOGIC AND HEMATOLOGIC DISEAS	939	63.21	1.09
946	ADULT MEDICAL EXAMINATION	127	52.77	1.11
947	WELL CHILD CARE	2455	40.94	0.45
948	COUNSELING	52	79.42	0.72
949	CONTRACEPTION AND PROCREATIVE MANAGEMENT	244	43.59	0.62
950	REPEAT PRESCRIPTION	9	56.72	0.67
951	NONSPECIFIC SIGNS & SYMPTOMS & OTHER CON	3774	91.55	1.14
959	ADMITTED OR DIED	5721	85.29	0.75

APPENDIX L

EXCERPTS FROM RELATIVE VALUE UNITS TABLE

APPENDIX L. EXCERPT FROM RELATIVE VALUE UNITS TABLE

SAMPLE OF COMPLETE SETS

HCPCS	MOD1	STATUS	DESC	WORK	PRACEXP	MALPRAC	TOTALRVU	SOURCE	GLOBAL
P3001		X	SCREENING PAP SMEAR, CERVICAL	0.00	0.00	0.00	0.00		XXX
P3001	26	A	SCREENING PAP SMEAR, CERVICAL	0.44	0.33	0.04	0.81	2	XXX
Q0035		A	CARDIOKYMOGRAPHY	0.18	0.42	0.03	0.63	2	XXX
Q0035	TC	A	CARDIOKYMOGRAPHY	0.00	0.30	0.02	0.32		XXX
Q0035	26	A	CARDIOKYMOGRAPHY	0.18	0.12	0.01	0.31	2	XXX
51725		A	SIMPLE CYSTOMETROGRAM	1.59	1.06	0.11	2.76	2	ZZZ
51725	TC	A	SIMPLE CYSTOMETROGRAM	0.00	0.39	0.04	0.43		ZZZ
51725	26	A	SIMPLE CYSTOMETROGRAM	1.59	0.67	0.07	2.33	2	ZZZ
51726		A	COMPLEX CYSTOMETROGRAM	1.80	1.41	0.14	3.35	1	ZZZ
51726	TC	A	COMPLEX CYSTOMETROGRAM	0.00	0.56	0.06	0.62		ZZZ
51726	26	A	COMPLEX CYSTOMETROGRAM	1.80	0.85	0.08	2.73	1	ZZZ
51736		A	URINE FLOW MEASUREMENT	0.88	0.47	0.05	1.40	1	ZZZ
51736	TC	A	URINE FLOW MEASUREMENT	0.00	0.20	0.02	0.22		ZZZ
51736	26	A	URINE FLOW MEASUREMENT	0.88	0.27	0.03	1.18	1	ZZZ
51739		A	SOUND RECORD OF URINE STREAM	0.97	0.86	0.09	1.92	1	ZZZ
51739	TC	A	SOUND RECORD OF URINE STREAM	0.00	0.17	0.02	0.19		ZZZ
51739	26	A	SOUND RECORD OF URINE STREAM	0.97	0.69	0.07	1.73	1	ZZZ
51741		A	ELECTRO-UROFLOWMETRY, FIRST	1.66	0.64	0.07	2.37	1	ZZZ
51741	TC	A	ELECTRO-UROFLOWMETRY, FIRST	0.00	0.28	0.03	0.31		ZZZ
51741	26	A	ELECTRO-UROFLOWMETRY, FIRST	1.66	0.36	0.04	2.06	1	ZZZ
51772		A	URETHRA PRESSURE PROFILE	1.70	1.12	0.12	2.94	1	ZZZ
51772	TC	A	URETHRA PRESSURE PROFILE	0.00	0.56	0.06	0.62		ZZZ
51772	26	A	URETHRA PRESSURE PROFILE	1.70	0.56	0.06	2.32	1	ZZZ
51785		A	ANAL/URINARY MUSCLE STUDY	1.62	1.10	0.11	2.83	1	ZZZ
51785	TC	A	ANAL/URINARY MUSCLE STUDY	0.00	0.41	0.04	0.45		ZZZ
51785	26	A	ANAL/URINARY MUSCLE STUDY	1.62	0.69	0.07	2.38	1	ZZZ
51792		A	URINARY REFLEX STUDY	1.15	1.01	0.10	2.26	1	ZZZ
51792	TC	A	URINARY REFLEX STUDY	0.00	0.38	0.04	0.42		ZZZ
51792	26	A	URINARY REFLEX STUDY	1.15	0.63	0.06	1.84	1	ZZZ

HIGHEST RBRVS UNITS

HCPCS	MODI	STATUS	DESC	WORK	PRACEXP	MALPRAC	TOTALRVU	SOURCE	GLOBAL
33865		A	ASCENDING AORTA GRAFT	38.21	54.96	9.47	102.64	2	090
33877		A	THORACOABDOMINAL GRAFT	42.46	46.48	8.83	97.77	2	090
33870		A	TRANSVERSE AORTIC ARCH GRAFT	39.77	46.68	8.48	94.93	1	090
61521		A	REMOVAL OF BRAIN LESION	41.61	34.75	6.17	82.53	1	090
61520		A	REMOVAL OF BRAIN LESION	40.41	35.67	6.21	82.29	1	090
33516		A	CORONARY ARTERIES BYPASS	30.55	42.57	7.51	80.63	2	090
33860		A	ASCENDING AORTA GRAFT	36.09	36.58	6.51	79.18	2	090
33514		A	CORONARY ARTERIES BYPASS	29.17	42.27	7.43	78.87	2	090
51596		A	REMOVE BLADDER, CREATE POUCH	38.21	36.76	3.64	78.61	2	090
61711		A	FUSION OF SKULL ARTERIES	36.49	34.82	6.53	77.84	1	090
63252		A	REVISE SPINAL CORD VESSELS	40.94	29.77	5.81	76.52	1	090
33513		A	CORONARY ARTERIES BYPASS	27.79	41.27	7.31	76.37	2	090
61700		A	INNER SKULL VESSEL SURGERY	36.70	33.39	5.98	76.07	1	090
63250		A	REVISE SPINAL CORD VESSELS	40.74	29.49	5.50	75.73	1	090
51595		A	REMOVE BLADDER; REVISE TRACT	36.09	35.62	3.52	75.23	2	090

LOWEST RBRVS UNITS

HCPCS	MODI	STATUS	DESC	WORK	PRACEXP	MALPRAC	TOTALRVU	SOURCE	GLOBAL
88125	TC	A	FORENSIC CYTOPATHOLOGY	0.00	0.02	0.00	0.02		XXX
93770	TC	A	MEASURE VENOUS PRESSURE	0.00	0.02	0.00	0.02		XXX
88300	TC	A	TISSUE EXAM BY PATHOLOGIST	0.00	0.05	0.00	0.05		XXX
88311	TC	A	DECALCIFY TISSUE	0.00	0.05	0.00	0.05		XXX
88313	TC	A	SPECIAL STAINS	0.00	0.05	0.00	0.05		XXX
88312	TC	A	SPECIAL STAINS	0.00	0.06	0.00	0.06		XXX
88318	TC	A	CHEMICAL HISTOCHEMISTRY	0.00	0.06	0.00	0.06		XXX
78890	26	A	AUTOMATED DATA, NUCLEAR MED	0.05	0.02	0.00	0.07	2	XXX
91000	TC	A	ESOPHAGEAL INTUBATION	0.00	0.07	0.01	0.08		000
88160	TC	A	CYTOPATHOLOGY	0.00	0.08	0.01	0.09		XXX
88180	TC	A	CELL MARKER STUDY	0.00	0.08	0.01	0.09		XXX
92572		A	STAGGERED SPONDAIC WORD TEST	0.00	0.08	0.01	0.09		XXX
94150	TC	A	VITAL CAPACITY TEST	0.00	0.08	0.01	0.09		XXX
88106	TC	A	MICROSCOPIC EXAM OF CELLS	0.00	0.09	0.01	0.10		XXX
94250	TC	A	EXPIRED GAS COLLECTION	0.00	0.09	0.01	0.10		XXX

APPENDIX M

ASSIGNMENT OF RESOURCE-BASED RELATIVE VALUES TO SAMPLE ENCOUNTER FILE SERVICES, BY RBRVS STATUS

APPENDIX M

Assignment of Resource-Based Relative Values to Sample Encounter File Services, by RBRVS Status

RBRVS STATUS	SERVICES ASSIGNED RBRVS TOTAL	SERVICES ASSIGNED RBRVS PERCENT	AMOUNTS ALLOWED FOR SVCS ASSIGNED RBRVS TOTAL	AMOUNTS ALLOWED FOR SVCS ASSIGNED RBRVS PERCENT	NUMBER OF ENCOUNTERS
ACTIVE CODE	270,097	56.3	$19,297,585.74	74.1	195,799
BUNDLED CODE	72,658	15.1	2,432,956.58	9.3	24,479
CARRIER PRICED	16,897	3.5	1,802,638.81	6.9	11,925
DELETED CODES	4,654	1.0	378,120.26	1.4	1,859
EXCLUDED, PAY BY RC METH	3,203	0.7	43,812.65	0.2	3,191
NONCOVERED SERVICES	947	0.2	25,885.53	0.1	694
INJECTIONS	7,161	1.5	100,167.45	0.4	5,002
DELETED VISIT CODE	2,337	0.5	61,586.35	0.2	2,310
STATUTORY EXCLUSION	97,422	20.3	1,760,917.76	6.8	72,400
ELECTROCARDIOGRAMS	4,684	1.0	137,302.15	0.5	4,000
TOTAL	480,060	100.0	$26,040,973.28	100.00	321,659

APPENDIX N

MEDICARE FEE SCHEDULE PROCEDURES FLAGGED FOR BUNDLING

(STATUS CODE "B")

APPENDIX N

Medicare Fee Schedule Procedures Flagged for Bundling (Status Code "B")

HCPCS	STATUS	DESCRIPTION	TOTAL RVU	GLOBAL
15850	B	REMOVAL OF SUTURES	0.00	XXX
90889	B	PREPARATION OF REPORT	0.00	XXX
92531	B	SPONTANEOUS NYSTAGMUS STUDY	0.00	XXX
92532	B	POSITIONAL NYSTAGMUS STUDY	0.00	XXX
92533	B	CALORIC VESTIBULAR TEST	0.00	XXX
92534	B	OPTOKINETIC NYSTAGMUS	0.00	XXX
94700	B	BLOOD GAS ANALYSIS	0.00	XXX
94710	B	ARTERIAL BLOOD GAS ANALYSES	0.00	XXX
95880	B	CEREBRAL APHASIA TESTING	0.00	XXX
95881	B	CEREBRAL DEVELOPMENTAL TEST	0.00	XXX
95882	B	COGNITIVE FUNCTION TESTING	0.00	XXX
96545	B	PROVIDE CHEMOTHERAPY AGENT	0.00	XXX
99000	B	SPECIMEN HANDLING	0.00	XXX
99001	B	SPECIMEN HANDLING	0.00	XXX
99002	B	DEVICE HANDLING	0.00	XXX
99024	B	POST-OP FOLLOW-UP VISIT	0.00	XXX
99025	B	INITIAL SURGICAL EVALUATION	0.00	XXX
99050	B	POST-OP FOLLOW-UP VISIT	0.00	XXX
99052	B	MEDICAL SERVICES AT NIGHT	0.00	XXX
99054	B	MEDICAL SERVICES,UNUSUAL HRS	0.00	XXX
99056	B	NON-OFFICE MEDICAL SERVICES	0.00	XXX
99058	B	OFFICE EMERGENCY CARE	0.00	XXX
99070	B	SPECIAL SUPPLIES	0.00	XXX
99071	B	PATIENT EDUCATION MATERIALS	0.00	XXX
99078	B	GROUP HEALTH EDUCATION	0.00	XXX
99080	B	SPECIAL REPORTS OR FORMS	0.00	XXX
99090	B	COMPUTER DATA ANALYSIS	0.00	XXX
99150	B	PROLONGED MD ATTENDANCE	0.00	XXX
99151	B	PROLONGED MD ATTENDANCE	0.00	XXX
99288	B	DIRECT ADVANCED LIFE SUPPORT	0.00	XXX
99361	B	PHYSICIAN/TEAM CONFERENCE	0.00	XXX
99362	B	PHYSICIAN/TEAM CONFERENCE	0.00	XXX
99371	B	PHYSICIAN PHONE CONSULTATION	0.00	XXX
99372	B	PHYSICIAN PHONE CONSULTATION	0.00	XXX
99373	B	PHYSICIAN PHONE CONSULTATION	0.00	XXX